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**How Do Counsellors and Psychotherapists Understand Diet and  
Nutrition as Part of the Therapy Process? A Heuristic Study**

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## **Abstract**

Expert opinion and information in the public domain suggest that an individual's dietary and nutritional intake may be important factors in both physical and mental health. However, at this time in the counselling and psychotherapy field, it is not common for therapists to address issues of dietary intake and nutrition with clients.

Further to quantitative studies exploring therapists' inclusion of such factors in their work, this qualitative heuristic study explores the perceptions and beliefs of six qualified counsellors and psychotherapists and how they understand dietary and nutritional information to be relevant as part of the therapeutic process with clients.

Data was gathered with semi-structured telephone interviews and analysed using interpretative phenomenological analysis. Findings suggest that the personal history and lifestyle of the therapist may be significant in such an approach, as well as the professional maturity of the therapist. Maintaining the therapeutic relationship, therapist self-awareness and professional competence were also discussed.

Implications for practice include the consideration of multidisciplinary working and developing appropriate training for practitioners in this area.

**Declaration**

The work is original and has not been submitted previously in support of any qualification or course.

Signed.....

## **Acknowledgements**

I would like to sincerely thank my six participants for their valuable time, given in the midst of busy schedules, and for sharing both their professional and personal experiences with me. Without their willingness to share these views and their passion for the subject, this study would not have been possible.

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## **List of Abbreviations**

ADHD	Attention Deficit Hyperactive Disorder
BACP	British Association for Counselling and Psychotherapy
BBC	British Broadcasting Corporation
EAP	Employee Assistance Programme
GP	General Practitioner
IPA	Interpretative Phenomenological Analysis
NHS	National Health Service
NICE	National Institute for Health and Clinical Excellence
UK	United Kingdom

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## **Chapter 1: Introduction**

The food and drink we consume – what, when and how - are universal and necessary considerations that mean food can subsequently represent a myriad of things from person to person. For some individuals, food may simply exist as a means of fuelling the body. However, the provision, preparation, and sharing of food and drink also hold cultural meaning: a family meal, a cup of tea or champagne toast - may symbolise love, celebration or comfort as well as family and community (Christensen, 1996b; Christensen & Brooks, 2006). Similarly, the scarcity or withholding of food can be a significant and painful experience. Issues of diet and nutrition exist in a social and political sphere, with access to food and nutritional education affected by economic factors, social status and living environment.

At the same time, dietary behaviour exists at a biological level, i.e. our food and drink choices affect our body and our brain – fundamentally, our physical development and function and much discussion has taken place in popular newspapers regarding the relationship between food intake and physical health (McKie, 2011). Often based on selective research findings, there are many claims about the benefits of ‘super foods’ (NHS Choices, 2011); whilst others report the ‘protective’ effects of certain foods against disease, such as cancer (Atkinson, 2010), and the rising threat of obesity and heart disease to the health of the nation (Malhotra, 2012).

In terms of mental health, the relevance of diet and nutritional supplementation has also been reported highlighting, for example, the intake of fish oils to treat psychotic illness (BBC, 2010) and the links between a diet high in processed foods and depression (BBC, 2009). The damaging effects of regular dietary intake of trans fats on the brain and subsequent links with depression and manic behaviour have also been emphasised (Hogg, 2011).

Possibly due to this level of coverage and public discussion, it is now commonly accepted that what and how we eat has a degree of effect upon both our physical and mental health. In acknowledging this, it would therefore seem that information of potential value to clients who present with psychological concerns is available; that their chances of improved health may not just lie within the resolution of emotional disorder but that clients could benefit from considering the possibility of physiological disturbance due to diet and/or nutritional factors.

### **Aims and objectives**

One of the most pertinent questions regarding this topic has to be about the appropriateness of such material within the therapeutic process – is it relevant or even possible to work with this material with clients? If therapists are aware of factors that may increase or alleviate distress or discomfort for clients, is it in fact part of the therapist's role at all to engage with such information and, if so, how might this be achieved and how does this integrate with an existing theoretical orientation?

The researcher's discussions with fellow practitioners indicated varying degrees of awareness or lack of supportive opportunities to consider the place of diet within their client work, with any interest in dietary/nutritional issues usually having more personal origins. For many counsellors and psychotherapists, it seems issues of diet/nutrition are regarded as something separate from their practice with clients.

Indeed, it is not commonly understood as standard practice that counsellors or psychotherapists to engage with a client's dietary intake or nutritional factors during assessment interviews or as part of the therapy process itself. However, many therapists will comfortably engage in discussion with clients about their alcohol intake and use of recreational drugs (Burks & Keeley, 1989); even caffeine and its potential impact on sleep, stress and anxiety symptoms may be discussed by therapists.

Pertinently, when the researcher's initial training as a person-centred therapist is taken into account, plus discussions with colleagues and peers, it would seem that no specific education is usually given to trainees regarding the actual effects of these substances on clients' mental and physical health, indicating that counselling/psychotherapy training does not necessarily equip therapists to work fully with these issues.

On the subject of diet and nutrition in particular, some argue that this remains the work of a trained nutrition expert (Dwyer, 2000; White, 2009), yet there have been calls by others for greater awareness of food and its effects within the psychological talking therapies. By educating practitioners about the connections between diet, nutrition and mental health symptoms, it is argued that a client's problems may be more adequately assessed and addressed, providing the client with the best opportunity for wellness (Edwards, 2002; Holford, 2004; Pointon, 2006; Walsh, 2011).

The research (Burks & Keeley, 1989; Royak-Schaler, 1984) and this researcher's therapeutic experience both identify links between the personal lifestyle of the therapist and therapeutic work with clients. However, a clearer picture is required to understand more fully when and why practitioners may be applying dietary and nutritional information when engaging with client's psychological or physical distress. This study now aims to explore the views and experience of therapists in order to clarify ideas about incorporating what may potentially be important knowledge into therapeutic practice with clients (Etherington, 2004a).

A qualitative heuristic approach has been chosen for this study and of particular interest to the researcher are the factors that influence each therapist's perception of diet and nutrition within the therapeutic process; its relevance to each client's presenting issues; how they approach dietary/nutritional issues in session and the dilemmas they may face within their client work when addressing such issues.

The ultimate objective is to improve outcomes for clients: through increasing awareness and understanding amongst psychological therapists and mental health practitioners - whether already engaging with these types of methods and ideas or not previously aware of such causes of client distress – they may consider the relevance of these issues for their own client work in search of best and most effective practice.

A further desirable outcome of this study would be the stimulation and debate of dietary and nutritional issues in counselling and psychotherapy both within the field itself and with those working within the field of nutrition. To encourage dialogue between the two fields would be an ideal way of exploring constructive ways forward that may be of huge benefit to clients overall health and well-being. If further studies can be conducted on this basis, I believe it has significant implications for future psychotherapy and counsellor training courses (Pointon, 2006).

## **Chapter 2: Literature Review**

There were 4 primary intentions in reviewing the literature for this study:

- To explore the extent of research within the nutritional and psychological fields - the effects of specific foods, vitamins and minerals
- To investigate the areas of common agreement or dispute regarding the evidence for the biological and psychological impact of foods and nutrients
- To consider published opinion regarding diet and nutrition for mental health practitioners; i.e. if or how this knowledge may be utilised by psychological therapists in their work with clients
- To discover existing studies of psychological therapists using dietary factors with their clients during therapy.

Literature included in this review needed to focus on the impact of nutrients and food directly upon mental health and physical conditions affecting mood in a manner appropriate to the understanding of a mental health practitioner. Whilst this review includes studies focused on the impact of various food-related substances and nutrients, studies concerned with complex nutrient interactions were excluded. Digital and printed information provided by mental health organisations and the National Health Service (NHS) was included as this is widely available to the general public and therefore significant for discussion.

### **Literature search**

Using key search terms such as counsellor, psychotherapist, therapist, counselling, psychotherapy, therapy, beliefs, values, nutrition, diet, food, mood, health, mental health, mental illness and clients, searches were conducted within databases such as *PsycINFO* and *SocINDEX*, accessing journals and book chapters on psychotherapy and counselling, psychology, nutrition and health care. Google also identified a number of studies, mental

health websites, forums and newspaper articles. To be included, literature needed to be in English and published since 1970, thereby enabling consideration of the most recent evidence and opinion.

Many studies were found that explored the effects of specific nutrients such as magnesium, folate and B vitamins, omega-3 and omega-6 on brain function and mental health. Studies of specific food types were also apparent in the literature exploring links between diet, mental health and behaviour: processed foods with high sugar content, for example, and caffeinated or high sugar drinks are identified as significant in terms of emotional health.

Several areas of mental health appear to have received significant attention in terms of diet and nutrition: depression, bipolar disorder and schizophrenia have all been studied as well as attention deficit hyperactive disorder (ADHD) and behavioural problems, for example, aggressive and violent behaviour. Biochemical imbalances such as dysglycemia (fluctuating blood sugar) are highlighted as producing a range of mental and emotional disturbance, e.g. anxiety, mood swings, depression and forgetfulness. Food intolerance and allergies are also linked with mood swings and depression as well as aggression and sleeping difficulties (Holford, 2004).

Studies found within the literature exploring connections between diet, nutrition, mental health and behaviour will now be discussed, as follows:

- Studies concerned with depression; vitamin B deficiency; bipolar disorder and schizophrenia; ADHD and aggressive behaviour
- Studies considering the relevance of dietary patterns
- A parliamentary report's findings
- Studies and published opinion concerning the application of nutritional and dietary factors to therapy with clients

- The issue of therapist training
- A multidisciplinary approach to mental health
- Online information and resources

### **Linking diet and nutrition with mental health and behaviour**

A selection of research studies is now presented exploring a range of dietary factors and their potential connections to psychological symptoms.

#### *Depression*

The search revealed that in terms of diet and nutrition, depression in particular has attracted much attention. Holford (2004), a psychologist and now a leading figure in nutritional research and health issues, discusses the importance of omega-3 oils in combating depression, notably a more robust area in terms of evidence than other nutrients (Adams, Minogue & Lucock, 2010), as well as maintaining blood sugar balance and avoiding high sugar or refined foods in order to manage symptoms.

Christensen (1991, 1996a, 1996b) - who has highlighted the methodological complexities when researching these types of connections - has conducted considerable research into the links between depression and sucrose, carbohydrates and caffeine use. His double-blind placebo controlled study demonstrated a reduction in subjects' emotional distress and depressive symptoms after the elimination of caffeine and refined sucrose, with symptoms returning on reintroduction of these substances. However, he also goes on to describe the need for a process to recognise individuals who might benefit from such dietary interventions, for example, he identified that those showing hypoglycaemic symptoms often experienced success, and that an individual's beliefs about food will impact on the physical effect of substances (1996b). Christensen and Brooks (2006) have also explored the 'bidirectional' nature of the food and mood connection, positing that how we feel will influence the foods we choose to eat.

From a nutritional perspective, a large scale quantitative study by Jacka et al. (2009) explored the relationship between magnesium intake and depression, with results showing correlations indicative of a connection, namely that inadequate magnesium could contribute to increased depressive symptoms. This study was tentative in its conclusions however, due to potential unknown confounding factors and recognised that the direction of cause, i.e. poor nutrition leads to poor mental health or vice versa, was inconclusive.

Other views were found that questioned the research into dietary links with mental health, deeming the evidence in research inconclusive (Dwyer, 2000), and highlighting methodological difficulties in making causal connections - namely that identifying specific causal factors in such studies is difficult and that individuals vary in their sensitivity to foods and nutrients, a point echoed by Christensen (1996b). However, a more recent review by Harbottle and Schonfelder (2008) goes on to state that although a lack of conclusive evidence is available, studies into omega-3 oils and evidence of efficacy in the treatment of depression are still relevant, though not sufficient as a sole treatment and further studies are required. In terms of relevance for this study's focus, this review would indicate that for clients managing depression, reflection on their omega-3 intake would be a worthwhile consideration.

#### *B vitamin deficiency and psychological distress*

Holford (2004) describes how deficiency in certain B vitamins affects the brain's neurotransmitters potentially leading to anxiety and tension, delusions or illusions and mood swings. Supporting this opinion are the findings of a 50 year cohort study (Mishra, McNaughton, O'Connell, Prynne & Kuh, 2009) of women in middle age designed to explore a connection between B vitamin intake in childhood and adulthood and subsequent adult mental health, though findings showed that only the low intake of vitamin B12 in adulthood related to psychological distress in adulthood. Whilst this study was limited in terms of



gender and age, this still indicates potential benefits of supplementation for women of mid-life when managing symptoms of mental ill health.

#### *Bipolar disorder and schizophrenia*

These mental health conditions have attracted much discussion in dietary and nutritional terms, with nutritional deficiencies highlighted, especially omega-3 oils (Holford, 2004; Walsh, 2011). Yet, a recent review of the evidence for the effect of omega-3 fatty acids on bipolar disorder (Montgomery & Richardson, 2008) found limited results upon which to conclude that this nutrient is effective for treating this condition. Whilst the depressive element of the condition seemed to respond, supporting previous positive outcomes for omega-3 and unipolar depression, no change was found in response to omega-3 intake for manic episodes. Limitations in reviewing the studies included the variations in dosage between studies and the small number of high quality studies in existence. This review then would imply caution when considering these conditions in terms of treatment with omega-3 until further research has been established.

#### *Attention-deficit hyperactivity disorder (ADHD)*

Links with food intolerance and sugar intake have been widely investigated, and Christensen (1996b) argues that there has been no conclusive evidence regarding sugar intake and ADHD. However, since this observation, Schnoll, Burshteyn and Cea-Aravena (2003) have taken an overview of the studies into a nutritional approach and found diet to be an important influence in the condition. Whilst they state that it is impossible to generalise for all children with ADHD due to different responses to problem substances, they conclude that there is increasing evidence of the significance of diet and that 'there is a subset of children with behavioural problems who are sensitive...to food components that may...contribute to their hyperactive behaviour' (p.73).

Pelsser, Frankena, Toorman, Savelkoul, Pereira and Buitelaar (2009) conclude that their study, an elimination diet conducted with a group of twenty-seven children, shows diet to be of significance in the treatment of ADHD. Their results showed that at the close of the study 70 per cent of the children no longer met the ADHD criteria. However, there were many limitations for this study, including a lack of placebo and the nature of an open-labelled controlled trial. Nevertheless, this research is interesting as it considers within its limitations aspects such as the relationships of the individual possibly affecting improvement, e.g. increased attention for the children and adults altering behaviour – areas relevant for counsellors and psychotherapists.

#### *Aggressive behaviour*

Studies have been conducted of prisoners treated with nutritional supplements (Gesch, Hammond, Hampson, Eves & Crowder, 2002). Zaalberg, Nijman, Bulten, Stroosma and Staak (2010) describe the links made to date between deficient nutritional states of prisoners and aggressive behaviour. In their randomised, double-blind, placebo controlled trial providing nutritional supplements to offenders, the results showed a reduction of reported incidents though other areas showed no improvement. This relatively short study (1-3 months) was limited by studying prisoners only, as well as potentially being too short a duration for the full effects of nutritional supplementation to occur. Measurements also relied not only on self-assessment by the subjects but also on staff who may have been influenced by relationships within prison life.

The aforementioned studies tended to focus on linking the impact of specific substances upon various mental health symptoms. Whilst they provide a useful illustration of how nutritional status may impact upon an individual, on overview would indicate caution for practitioners when attributing causal factors to mental ill health due to the individuality of response to a particular substance.

## **Dietary patterns and mental health**

More recently, studies have moved from focussing on impacts of individual nutrients to studies into the eating patterns of individuals. These types of studies seem to be particularly helpful when considering how an individual in psychological therapy might achieve beneficial changes from dietary improvement.

A quantitative study by Akbaraly et al. (2009) researched the dietary patterns 3486 middle-aged participants in relation to depressive symptoms. Interested in the cumulative effects of diet, results showed that after a 5 year period participants with the highest intake of wholefood were less likely to report symptoms of depression than compared with those with high intake of processed foods, indicating that a wholefood dietary pattern was protective against depression. Also, a randomised controlled study into cholesterol-lowering diets not only achieved lowered cholesterol but also found reductions in depressive symptoms (Weidner, Connor, Gerhard, Duell & Connor, 2009). Interestingly, these researchers speculated that the psychological improvements may be related to the individuals' increased feelings of self-efficacy, a factor worthy of consideration in terms of therapeutic practice.

Other researchers have been concerned with adolescent mental health. One cross-sectional study (Jacka et al, 2011) found relationships between young peoples' diet and their mental health; that healthier diets - a diet low in processed and high sugar foods plus an increased intake of fresh and wholefoods - were mirrored by improvements in mental health. These findings indicate particular importance for the consideration of dietary factors for young people, as mental health problems have been found to frequently manifest in adolescence (Hogg, 2011).

## **The Associate Parliamentary Food and Health Forum report and recommendations**

The Associate Parliamentary Food and Health Forum (2008) conducted a year long inquiry into the research and evidence concerning diet and behaviour of children, young people and criminal offenders, which also encompassed brain function and mental health.

The report concludes with a considerable list of recommendations, which include the following:

- More NHS trusts to adopt the approach developed by nutritionist Kevin Williamson of the NHS Early Intervention service, that provided nutritional assessments to individuals presenting with symptoms of depression and psychosis;
- For the 'scanty training of GPs and other medical professionals in nutrition and diet' leading to diminished care for patients, to be addressed by the Royal Medical Colleges and the General Medical Council;
- Serious consideration by the government of the effects of diet on the behaviour of prisoners and young offenders and for further research into the links between nutrition, brain development and mental health to be supported and further expanded by the Foods Standards Agency, the Department of Health, the Department for Children, Schools and Families and the Ministry of Justice.

Though this report was limited by a focus on omega-3 and omega-6 fatty acids and the impact on specific groups, it would seem to have real relevance for practitioners when considering the relevance of a client's diet as contributory to the route to recovery.

### **Diet, nutrition and applications in therapy**

A practical application of dietary knowledge within a therapeutic context pertinent to this study is illustrated by Edwards' case study (2002), which describes a client with hypoglycaemia attending couple therapy. Through the therapist's dietary enquiries and the client subsequently monitoring his eating habits and blood sugar, the client successfully reduced his agitation, which seemed to be a root cause of conflict with his wife, therefore improving their relationship considerably.

Parker & Watkins (2002) present a case vignette to illustrate the effects of intolerance on an individual's mental health and the importance of practitioner awareness of certain substances and interactions. It outlines how a particularly self-aware male patient, after years of physical intolerance to psychotropic medication and personal endeavours to reduce his symptoms, worked with an allergy specialist and identified other dietary allergies. Subsequently supported in an elimination diet the client went on to achieve a life relatively free of mental health symptoms.

Christensen (1991) recommends inclusion of diet and nutrition in an adjunctive approach to therapy, through the use of a dietary assessment, employing a dietary assessment alongside psychotherapy to gain the most rapid results. Such a process, however, would require specialist knowledge not necessarily held by an average counsellor or psychotherapist.

The question of a client's willingness to implement changes is also of relevance here and considered by the study of Jorm, Medway, Christensen, Korten, Jacomb and Rodgers (2000) who found that interventions supposedly believed by clients to be potentially helpful for depression, were not always reflected in the eventual choices made by clients. Though this study showed that diet and nutritional changes were in fact implemented more than the initial beliefs ratings would have suggested, these choices were often influenced by perceived difficulty, cost and accessibility.

### **Nutritional training for practitioners**

Whilst the literature reflected a group of opinions recommending the inclusion of diet and nutrition in the consideration of mental health issues, this was often followed by the issue of acquiring appropriate knowledge and concerns for practitioner competence were raised. White (2009) strongly advocates the awareness of nutrition and diet in mental health practitioners but places emphasis on the necessity of adequate training and education, a sentiment echoed by Burks and Keeley (1989) and Dwyer (2000).

During his interview with *Therapy Today* (Pointon, 2006), Holford puts forward a case for the education of therapists in nutritional issues to enable them to assess and work with clients more efficiently. Walsh (2011) recognises too that diet and nutrition are amongst the important lifestyle factors in addressing mental health, and strongly encourages practitioner attention to such information when working with clients. However, he continues to identify potential barriers to such working, including the effort necessary by the practitioner to become familiar with the wealth of literature available, application that can be deemed essential in terms of a practitioner's professional development (Rønnestad & Skovholt, 2003) and pertinent to this study.

### **A multidisciplinary approach**

Further appropriate considerations for this study were highlighted by the following research. A recent small-scale study considered the observations of practitioners in how their clients with bipolar disorder were affected by diet and nutritional factors (Lewisham Counselling & Counsellor Training Associates, 2011). Though this study was limited by its size and data based on practitioner perceptions of clients' mental health, the conclusions indicated links between diet and bipolar disorder symptoms, with significant implications for the knowledge of therapists working with this group. Significantly, however, in addition to the need for increased practitioners' awareness through further training was the notion of a 'triadic working alliance' involving client, therapist and nutritionist.

The issue of involving other practitioners qualified in diet and nutrition was also raised in a recent review by Adams, Minogue and Lucock (2010). Exploring the place of diet and nutrition in mental health recovery, within the implications for practice it concluded that whilst practitioners' accessing appropriate training was important, it also highlighted how a multidisciplinary approach in particular may be especially beneficial for clients.

Valid for further reflection were the findings of Caldwell and Jorm (2000) showing that the views of practitioners, such as psychiatrists and mental health nurses, differed on the relevance of diet and nutrition to mental health. They concluded that for successful multidisciplinary working, awareness is required of the diversity of attitudes and beliefs amongst professionals involved in an individual's mental health care, with variations on what is believed to be most helpful. If ignored, this issue potentially leads to a lack of integrated care and is a pertinent consideration for counsellors and psychotherapists when working with clients.

### **Studies of therapists in practice**

Only two studies were found concerning psychological therapists' approach to dietary issues with clients: both American and published in the 1980s. Royak-Schaler and Feldman (1984) conducted a quantitative study using questionnaires into the health-promoting behaviours of 86 psychotherapists. They investigated 6 categories of behaviours, including dietary habits and alcohol consumption, hypothesising that practitioners' recommendations would be linked to their own lifestyle choices. Their results confirmed this, with therapists more likely to advocate the adoption of healthy habits they were personally familiar with. However, further research was indicated in order to understand more fully what prompted individual therapists to make such recommendations with their clients and identify the perceived barriers to engaging with such information.

A subsequent quantitative study by Burks and Keeley (1989) went some way towards investigating this when they considered therapists' beliefs and practice regarding both diet and exercise. Also using questionnaires, they gathered information from 232 therapists about their client groups, types of presenting problems, extent of therapist's knowledge and the frequency of recommendations. Their results showed that therapists tended to refer clients on for nutritional advice and were generally more confident to recommend exercise. Of particular interest to this study was the conflict described for some therapists with this type of

working with their theoretical orientation and that participants' use of recommendations despite limited knowledge, lead the authors to conclude that training in nutrition and exercise for psychological therapists would be highly desirable. The study concludes with a call for further exploration of therapists' recommendations to clients and the basis on which these are made.

Though these two pieces of research provide valuable insights into the practice of therapists, it seems that recent qualitative data conducted within the UK, is lacking. This study now aims to contribute to this existing literature by adding a qualitative element; expanding on the motivations for therapists and providing necessary insight into therapists' cognitive and emotional processes when considering diet and nutrition with clients.

### **Other Relevant Literature**

The search also revealed a wealth of digital information on websites provided by various mental health bodies discussing the links between diet, nutrition and mental health.

#### *Developing research for public health*

Prominent in this area are charitable organisations such as Food and Behaviour Research (2012) and Food for the Brain (2012a), both involved in research in this area, with a view to provide information to the public enabling them to attain good physical and mental health.

Food for the Brain in particular, works directly with individuals at their Brain Bio Centre using nutritional therapy assessments to work with a range of health concerns including mental health issues such as depression, psychosis, schizophrenia and bipolar disorder. They provide links to research and information about these conditions on their site with nutritional and dietary advice available to site users. Testimonials are also available to view (Food for the Brain, 2012b) and of particular interest to this research are testimonies of individuals who have used diet and nutrition to successfully manage or eliminate symptoms of ADHD, manic depression, social phobia, paranoid schizophrenia, psychosis, panic, anxiety and post-natal



depression. As a free and accessible source of information, these are substantial resources for practitioners wishing to research further about the potential links between diet, nutrition and mental health as well as useful for clients wishing to further learning.

#### *Provision of tools to support dietary exploration*

Mind, the mental health charity, provides considerable amounts of information to site users on diet, nutrition and mental health. These accessible materials available to buy or download include a 'food and mood' guide; a food and drink diary and lists of important elements for a 'healthy mind' that include water intake as well as essential fatty acids (Mind, 2012).

The Mental Health Foundation, the UK's leading mental health research, policy and service improvement charity, shares a similar attitude, providing links to free downloads which include a nutrients table detailing foods and nutrients for optimum mental health; 'mentally healthy' recipes and a food and mood diary (Mental Health Foundation, 2012).

The British Dietetic Association also provides an accessible fact sheet outlining potential links between food and mood (British Dietetic Association, 2010). Similarly, Students Against Depression, a charity that received an award for innovation from the British Association for Counselling and Psychotherapy (BACP) in 2006, provides information about mental health and dietary intake. For instance, recommending foods high in tryptophan – needed by the brain to manufacture serotonin – and the importance of stabilising blood sugar and intake of omegas-3 and 6 (Students Against Depression, 2012). Highly significant and pertinent to this study, the existence of these tools suggests acknowledgement of the relevance of diet by those involved in supporting those with mental health issues.

#### *NHS resources*

The approach of the NHS to diet and nutrition for mental health seemed to be inconsistent. The NHS Choices website provided by the NHS for public information and guidance

discusses these issues, but states 'that there is not enough evidence to say for certain that some foods relieve symptoms of depression' (NHS Choices, 2012). However, this cautious tone was not reflected in an NHS booklet on food and mood (NHS Manchester, 2006) with detailed information on how and what to eat to manage mood and mental health. In addition to this, Williamson, a senior nutritionist within the NHS also went on to develop a training programme (NHS, 2009) to enable NHS professionals working with service users/clients to apply nutritional information to mental health issues meaning that trainees on completion will be qualified to use nutritional information with service users/clients.

#### *Royal College of Psychiatrists*

This website discusses the relevance of diet and mental health in much more general terms, e.g. maintaining a 'healthy weight' and shares the view of NHS Choices stating a lack of evidence to promote the use of omega-3 supplements over anti-depressants. However, they do tentatively acknowledge that omega-3 may promote mental stability and may be an option for mood problems and schizophrenia (Royal College of Psychiatrists, 2012).

#### *The National Institute for Health and Clinical Excellence*

Noticeably, the body consulted by the government regarding public health and key in the development of the guidelines used by the NHS has no reference to diet and mental health on its website (NICE, 2012).

### **Conclusion**

When the existing research is considered, it would seem that there is a wide range of study and opinion regarding the effects of diet and nutrition upon mental health and the potential relevance for mental health practitioners. It is also apparent that established mental health bodies are providing information on food and mood for public use, indicating relevance for public health. At the same time, a lack of conclusive evidence in many areas means much is

still yet to be ascertained regarding the application of such information in psychological therapies.

This study seeks to further the investigation of therapeutic application as recommended by Royak-Shaler and Feldman (1984) and Burks and Keeley (1989). Addressing the apparent lack of qualitative data in this area, therapists' perceptions and beliefs around diet and nutrition will be explored, including how their subsequent understanding of this information then becomes part of the therapeutic process with their clients.

### **Chapter 3: Methodology**

#### **Philosophy and Design**

The aim of this study was to explore the experience of therapists: their perceptions, values, ideas and feelings about the inclusion of dietary information in their therapeutic process with clients and, in doing so, facilitate further consideration of the researcher's own positioning (Douglass & Moustakas, 1985; Moustakas, 1990). This required a qualitative stance which, with its focus on the 'subjective' or *perspectival* experience of individuals, operates from a different world view to that of established quantitative traditions (Maykut & Morehouse, 1994).

However, to work from a phenomenological stance, which required bracketing off the Self of the researcher or *epoche*, seemed questionable and unrealistic; the perspective of the researcher is always present whether acknowledged or not (Etherington, 2004b; McLeod, 2003; Willig, 2008) and, for this study, an opportunity to learn from a more personal journey may have been lost. Furthermore, in utilising the researcher's voice in a reflexive and transparent fashion, it seemed possible to facilitate an equality between reader and researcher; to give the reader a better idea of the individual conducting the research so that they may better understand and evaluate conclusions or insights (Etherington, 2004a, 2004b).

To serve the study's purpose most fully, a qualitative heuristic approach was chosen, the research existing as it does at a point along a phenomenological-heuristic spectrum. Whilst the inquiry requires a presentation of 'what is seen', it also aims to draw upon the researcher's experience transparently within the project (Moustakas, 1990; Willig, 2008).

In analysing the data the interpretative phenomenological analysis method (IPA) was selected in order to preserve the unique nature of the participants' accounts.

## **Participants**

With an interest in therapists' views on diet/nutrition issues in counselling and psychotherapy, the sample was necessarily purposive, aiming for maximum variation and homogenous. Inclusion criteria dictated that participants should be qualified counsellors or psychotherapists currently in supervised practice, sharing a belief in the relevance of diet/nutrition for their client work. All 6 participants met these criteria.

Criteria for exclusion included therapists working exclusively with eating disorders as this would have missed the purpose of the study, and therapists whose sole employer was the NHS, as permission had not been sought from the NHS ethics committee. All 6 participants worked in private practice or provided therapy for organisations. Detailed information about the 6 participants is presented in Figure 1.

## **Recruitment**

BACP's practitioner magazine, *Therapy Today*, and online research notice board were used to recruit participants (see Appendix B), as well as the circulation of email amongst colleagues, peers, other practitioners in the field of nutrition and psychological therapy and relevant organisations (see Appendix C). A poster was displayed in the staff room of a counselling organisation and a set of leaflets distributed (see Appendix A).

Participants made initial contact via email or telephone. All interviewees received information sheets (see Appendix D) and a pre-interview questionnaire (see Appendix E), which enabled the researcher to clarify that participants were not expecting to specifically explore eating disorders during interview, though experiences around disordered eating would be considered as a relevant element of practice for all participants. Consent to conduct and record the interview was acquired with a signed consent form via email or post (see Appendix F). On receipt of each consent form a code was assigned to protect participants' confidentiality.

Figure 1: Participant details

<i>Participant code</i>	<i>P1</i>	<i>P2</i>	<i>P3</i>	<i>P4</i>	<i>P5</i>	<i>P6</i>
<i>Gender</i>	Female	Female	Female	Female	Female	Female
<i>Length of career (yrs)</i>	40	20	12	24	22	40+
<i>Theoretical approach</i>	Integrative	Integrative	Integrative	Integrative	Eclectic	Eclectic
<i>Non-counselling/ psychotherapy training</i>		Nutrition training for mental health		Body work	Naturopathy	Medical nutrition Evolutionary biology
<i>Current work roles</i>	Therapist Supervisor Executive coach	Therapist Supervisor	Therapist Supervisor	Therapist Supervisor	Voluntary counsellor Independent counsellor Supervisor Lecturer	Therapist Consultant
<i>Current work settings</i>	Private practice GP surgery	Private practice University	Private practice Relate	Private practice University	Private practice Counselling organisation	Private practice Mental health drop-in Freelance within NHS
<i>Examples of previous work roles</i>	Mediator Editor - publishing	Marketing management	Teacher Family support worker	Counselling tutor Wholefood retail	Teaching for learning disabilities Yoga teacher	Mental health social worker Social services advisor Childcare consultancy Foster carer
<i>Examples of previous work settings/ provision</i>	University Samaritans Relate Mental health community Telephone counselling Workplace	NHS	NHS GP surgery	GP surgery FE college	FE colleges	NHS Mental health day centre

## Heuristic method and Data Collection

Moustakas (1990) provides guidelines for heuristic inquiry with 6 phases to structure what can be an organic and potentially amorphous process. The following descriptions can be seen as reflective of the researcher's experience of this study:

- *Initial engagement* sees the researcher recognise a question 'that holds important social meanings and personal, compelling implications' (p. 27).
- During the *Immersion* phase, the researcher 'lives' the question, savouring every opportunity to discuss and learn from their environment and others.
- *Incubation* allows gathered information to exist within the researcher without pressure until the next phase of *Illumination* occurs, bringing fresh insights or 'corrections of distorted understandings' (p. 29).
- *Explication* sees the analysis of the data involving close reflection and 'indwelling' leading to a creation of a new whole in *Creative Synthesis*.

Utilising a high degree of reflexive working in heuristic inquiry, the researcher is both subject and object of inquiry, using themselves as a tool for exploration, acknowledging the existence of a 'filter' through which participants accounts are rendered (Etherington, 2004a).

As a popular method of data collection in heuristic and reflexive research, the researcher chose a semi-structured interview to gather participant's accounts (see Appendix G). Though not completely non-directive as is fully consistent with heuristic theory, utilising a *general interview guide* (Patton, 1980, cited in Moustakas, 1990) allows for variety in experience, whilst ensuring coverage of the necessary areas by all participants and providing a clearer pathway in the analysis of the data (Spong, 2011). An hour-long interview was conducted by telephone and digitally recorded.

Rather than face-to-face interviews, it was decided to make use of telephone interviews. By using such an approach it was hoped several goals would be achieved:

- a) Increasing potential participation to anyone who could access a telephone,
- b) Minimising travel, and
- c) Reducing the influence of physical appearance on interviewees' responses – such issues being potentially powerful and the aim was for participants to be free to speak honestly.

However, this choice of interview method also meant that cues provided in participants' body language would be missed, as well as the researcher being unable to use her own visible behaviour and facial expressions to further the interview relationship. In addition, those not comfortable using a telephone may have been discouraged from applying to take part in the study.

Interaction through interview appeared to provide the best chance of each therapist fully engaging with the issues: through speaking aloud to an empathic other, there lay potential to bring the issues to life; to connect with their passion for the subject and ultimately allow new thought and understanding to occur for both interviewer and interviewee. It was hoped that unpredicted pathways might be further explored and developed, uncovering feelings, memories and ideas in pursuit of the individual's unique perspective and experience.

The choice to engage verbally and personally with participants during interview also seemed the most appropriate choice in terms of heuristic discovery. In heuristic investigation Douglass and Moustakas (1985) place emphasis on the act of gathering data through 'one's ability to encounter people and the world' (p. 51) and that this is 'no less important than the facility for plumbing one's own self experientially'. With the researcher's passionate interest



in the subject, an opportunity to connect more directly with like minds than might be achieved with a questionnaire, for example, seemed invaluable.

After the transcription of each interview a copy was emailed to all participants for approval with any details changed or omitted as appropriate. All participants understood that they could withdraw from the process at any time before analysis of the data began.

### **Data analysis**

Before choosing the interpretative phenomenological analysis method, ontological and epistemological positions were considered. Using a social constructionist perspective, it is understood that multiple knowledges and realities exist due to different interpretations of our environment and, in taking a relativist position, the researcher sees that the world is not orderly, placing emphasis on diversity of interpretation. In keeping with the heuristic approach, relativism also acknowledges that the researcher is central to the research process going on to construct the findings (Willig, 2008).

Therefore, with participant interviews complete, the researcher also conducted the interview process for herself in order to become as aware as possible of what she was bringing to the study (see Appendix I) and was able to clarify the purpose of the chosen analysis method more fully. Describing for herself the substantial array of influences when considering a client's dietary habits during therapy, it became important to try and retain the idiosyncratic nature of the participants' accounts. To facilitate the process of personal reflection further, the use of a journal, as suggested by Etherington (2004b), provided additional space for the development of ideas and responses to literature and incoming participant data.

IPA was deemed to be in keeping with the aims and philosophy of this study: to attain as clear an understanding as possible of each therapist's perception and experience of working with dietary issues with clients. In keeping with this method, each transcript was treated 'on

its own terms' (Smith, Flowers & Larkin, 2009, p. 100), thus allowing the idiosyncratic themes of each case to exist as far as possible. Nevertheless, the researcher acknowledges - that as part of the hermeneutic process her 'forestructures', as a result of analysing previous cases, will have been continually changed, influencing her perception of each new set of data (Smith, Flowers & Larkin, 2009).

Noting descriptive, linguistic and conceptual comments within the transcript, resulting themes were identified and finally assigned to a master theme until participants' accounts were represented as fully as possible (Smith, Flowers & Larkin, 2009).

### **Ethical Considerations**

Before the study was conducted ethical approval was obtained from the Research Ethics Committee at the University of Chester. As a BACP accredited therapist the researcher worked in terms of their ethical framework during all contact with participants (BACP, 2010). BACP ethical guidelines for research were also followed (Bond, 2004).

Issues of power imbalance are pertinent in relationships with participants and participant safety was seriously considered: food for some people is an extremely personal subject; each interviewee's history may include food-related problems and the researcher held this fact respectfully. Care was also taken to obtain full agreement regarding the final draft of the transcript before analysis took place.

In terms of the researcher's well-being, consideration was given to the potentially vulnerable position of visibility through heuristic inquiry and self-disclosure. With the aim to share her own process, a decision as to how much to 'show' was needed, an issue that Etherington (2004a) highlights, citing self-care as one of the guiding principles in the BACP framework for good practice (BACP, 2010).

## **Reflexive statement**

As a consequence of my own ill health 4 years prior to this study, issues of diet and nutrition were addressed in order to heal my physical and mental health. In the absence of any helpful diagnosis or improvement through medical intervention, my own explorations into improving my diet and nutrition saw my physical health recover drastically along with the alleviation of long-term intermittent depression and anxiety symptoms. During this period of discovery and change, food acquired and retains today a significant position in my life, my interest in the potential impact of diet growing considerably and constantly, perpetuated by continued reading, discussion with colleagues and encounters with others who share an interest in holistic health.

My developed awareness of dietary and/or nutritional issues prompted increasing consideration of clients' consumption (or not) of various foods and drink and the potential impact of their dietary habits upon their overall mental and physical well-being. When hearing clients describe their symptoms, e.g. anxiety, lethargy, sleeplessness or depression, I often considered how much of their emotional and mental distress might be reduced by addressing nutritional or food related issues; that alleviation of their mental distress may lie not simply within the psychological realm, but that other factors may also be of importance.

Personal experience, various health literature and discussions with others has lead me to believe that diet is relevant to the psychological therapeutic process, and my drive to conduct this study was led by an interest in achieving the best possible outcomes for my clients. I feel a genuine concern that if a client's dietary intake or dietary pattern is inadequate for healthy physical and mental function, then it could be in the interests of therapy to address this, i.e. to further a client's understanding about the impact that their dietary behaviours may be having, potentially exacerbating their problems. It seems that to leave these issues unaddressed or without at least basic understanding leaves both the therapist and client at a real disadvantage when pursuing desired results.

I am also passionate about the issue of empowerment and consequently, empowering my clients. With a personal history that contains experience of social oppression and a therapist with a career that has worked extensively with oppressed social groups, I understand the treatment of our bodies to be in part, as a result of education and available information, an essential aspect of empowerment. If as a therapist I am, in fact, in a position to offer information that may increase a client's well-being and effective management of their lives, as well as reduce clients' time/costs in seeking good mental (and physical) health, then I feel compelled to do so. However, for all the successful interventions that I have experienced when exploring diet with clients, there have been times when the information offered was met with ambivalence, confusion or disinterest. Such interactions would often leave me in a state of doubt, only to have my faith renewed when a client would return and report positive change after applying dietary changes.

Increasingly, I needed to collaborate with other therapists that felt a connection to such issues, to explore the views and experiences of those that also understood the information provided by various dietary experts to be relevant to psychological therapy. I was curious as to what extent these therapists would then use this knowledge – when, how, their rationale for doing so and how they might also manage any inner conflict or doubt. In analysing my participants' approaches to this type of working, it seemed possible to consider and question my own practice, thus further developing the notions I held about the relevance of diet to therapy. These ideas compounded and became the focus of this study.

### **Validity and Trustworthiness**

There is a critical balance within heuristic research of subjectivity and objectivity and it is clear that to embark upon such a study one must be prepared to completely engage with the data. Douglass and Moustakas (1985) note that in full acknowledgement of the subjectivity in heuristic research, namely the personal perspective, lies the 'most objective assessment' (p. 43). However, it is equally important to remain aware of the necessity to re-engage

objectively in order to create full meaning and new understanding; if the work becomes too indulgent or self-involved, it becomes less relevant to others, the readers seeing less of their selves in it (Etherington, 2004a).

In order for the researcher to become an integral part of the study and authentically visible the interview and transcription process was repeated for the researcher. This process aimed to highlight, as far as possible, the researcher's influence on the research process – on the study's design and the relationship with the interview questions posed to participants. With this information more clearly exposed, it was hoped to enable the investigation of data without subconsciously trying to portray the researcher's own ideas or views through participants' answers; the researcher's having already been heard and duly noted.

During analysis of the data, personal and epistemological reflexivity provided reflection and clarity and the researcher's impact upon the shape and nature of the study became clear. The study's overall design and aims - choice of categories and order of questions for interview; the focus of the question itself and the subsequent data identified as important during analysis - all of this is shaped by the researcher's personal history, values and political views, ultimately defining and limiting what may be discovered (Willig, 2008).

In asking participants how previous work settings had influenced their practice, this was because the researcher had felt her own work history to be important in her development as a therapist; when exploring how each therapist 'felt' about working with diet, this was reflective of the researcher's own experience of doubt and conflict.

The themes created during analysis inevitably resonate with the researcher's own experience. Crucially however, the final themes and master themes are intended primarily to capture and represent the experiences and views of participants. Ultimately, it is hoped that the reader will be able to weigh up the facts about the researcher, the research and the

outcomes for themselves (Denscombe, 2003; Etherington, 2004b; Elliot, Fischer, & Rennie, 1999; McLeod, 2003).

## **Chapter 4: Findings**

This study explored therapists' understanding of diet and nutrition as part of the therapy process. 6 fully qualified therapists currently in practice were interviewed and transcripts analysed using IPA.

17 themes were identified and organised under 4 master themes (A-D):

<i>Master theme</i>	<i>Theme</i>
A. Personal aspects of the therapist	Personal life history Personal lifestyle Therapist perceptions and beliefs regarding diet and nutrition Perceptions of the medical approach
B. Therapeutic approach and philosophy	Learning and development Attitudes to therapy Therapists' aims in therapy Maintaining the therapeutic alliance Client responsibility and collaboration
C. Diet and nutrition within the therapy process	Assessing clients' presenting issues Exploring diet as part of lifestyle and self-care Use of dietary intervention Client responses to interventions
D. Considering ethical practice	Working with competence Socio-economic issues in diet and nutrition Awareness of own process as therapist Experience of supervision

Each theme will be discussed in turn, with interviewee quotes providing illustration.

## **A. Personal aspects of the therapist**

### **Personal life history**

Participants were asked to consider how diet and nutrition had been a part of their lives with 5 out of 6 participants recounting memories of childhood. P2 described how her mother having ‘*cooked everything from scratch*’, and the family eating healthily, she ‘*grew up with a reasonable awareness of food.*’ P6 also spoke of positive associations with food:

*I can still link a lot of the memories of my mum and dad to food... many of my very positive memories of being cared for have a food element in them.*

For P4, food became politically relevant for her as a young woman:

*Food was a very important thing... processing of food... finding out about nutrition. Working in a wholefoods shop... it was a part of my life and part of my politics.*

Diet had also played a key part for half of the participants in managing personal ill health. For example, P5 describes how she had managed two serious conditions:

*I'm diabetic... I don't take medication. I've had serious cancer and come through it and I think it's if you're in the right frame of mind... with the food and nutrition.*

P2 spoke a ‘*journey and a quest*’ seeking ‘*a healthy balanced diet as a vegetarian*’ in order to manage her anaemia. P1 passionately explained of how omega 3 essential fatty acids ‘*transformed*’ her life, alleviating a painful eye condition. For P3, diet became important in caring for her son:

*I've got an autistic son... and found that there were certain [food] allergies that he had that affected him... his behaviour.*

### **Personal lifestyle**

5 out of 6 participants illustrated how an awareness of food and nutrition was integrated into their day-to-day lifestyle. The use of nutritional supplements was mentioned by P1, who in order to manage a debilitating eye condition told of how she would ‘*now max out on omega 3*’.



Explaining the personal relevance of diet and nutrition, P2 described how she had '*long been interested in it*' and that she aims for a balanced personal diet:

*It's very easy for me to eat fruit and I like vegetables too... I do have a sweet tooth... that's not good news, but I think I manage it pretty reasonably, because I do so much on the healthy food side.*

Other ways of managing diet for good health and well-being were also illustrated by P4 who knowingly avoids the negative impact of low blood sugar:

*I had breakfast before I talked to you and I knew that if I didn't eat my breakfast, it would affect our ability, my ability to enjoy this interview.*

P5's dietary awareness was expressed as strongly connected to her identity:

*Food and nutrition, it's just a passion really... Like I said before, it's part of me, it's what I do.*

Similarly, P4 illustrated how growing food and her home life were connected:

*I live with someone who grows food, grows organic vegetables... food is a big part of my life... still.*

### **Therapist perceptions and beliefs regarding diet/nutrition**

In clarifying ideas regarding the relevance of diet and/or nutrition for mental health, certain beliefs and perceptions held by interviewees were demonstrated. P1 described a belief '*healthy body, healthy mind*', akin to P3's assertion that '*we are what we eat*'. P5 emphasises this point also:

*I see it as a part of life that if you eat right, then you feel right. You've got lots of energy, you can concentrate better... keeps you on an even keel.*

P5 went on to reflect on public habits as a stark illustration of the need for dietary change:

*...obesity rates... the way peoples' behaviour is... that is down to what they're eating, what they're doing... I think it forms the whole personality.*

P2 communicated her understanding of the vital nature of healthy food and eating habits:

*We need life force, we need living energy... I find it so integral in life and to our job.*

P4 echoed this view saying '*it feels an essential part of life... next to breathing.*'

Half of participants described the symbolic nature of dietary habits, understanding eating well as an act of caring for one's self. P6 summarised this when she said:

*It's about looking after yourself, it's not just about the intake of food, it's making time for yourself, so food has... all sorts of implications.*

Through her work with vulnerable children, P6 illustrated an additional consideration:

*You have to realise that food might mean safety, hoarding food might mean safety.*

### **Perceptions of the medical approach**

When considering the benefits of diet and lifestyle, P5 reflected on the use of antidepressants for clients and spoke of how *'the majority of people who come and are on medication don't really want to take it, it's not what they really want to do'*. Relative to this, P1 spoke positively of a *'doctor that everybody wants to see'* who considered herbal alternatives to medication with patients who might express that *'I'm depressed but I don't want tablets'*.

However, 4 out of 6 participants commented on the inadequacy of GPs and the NHS on issues of diet and nutrition. Using an example of how her own eye condition went undiagnosed by doctors, P1 explained her anger and how she avoided unwanted medication:

*It's only omega 3 essential fatty acids! How dare [the doctors] not know this? ...talking to me about being on steroids for the rest of my life? I feel incandescent with rage.*

P4, who also disclosed inadequate diet/nutritional care after her own bowel operation with the NHS, expressed doubts as to the competence of GPs and the NHS to adequately address nutritional issues:

*There's a gap in the NHS where there's not enough nutritional advice ... If food is that basic, why [hasn't] the average GP got much nutritional expertise? ...Or why isn't there a nutritional expert at each GP surgery?*

P5 alluded to times that clients experienced a lack of improvement working with their doctor that she would then address:

*She was always tired and on edge... so I started to talk about what, you know, what she'd tried herself cos she was getting nowhere with the doctor.*

Similarly, P3 described a client's surprise that P3's suggestion of drinking water to resolve a physical problem hadn't been previously highlighted by his GP:

*He said, 'do you know, if somebody'd said this to me, if I'd gone to the doctor and he'd even said something about water drinking...*

## **B. Therapeutic approach and philosophy**

### **Learning and development**

When talking about the development of their practice, therapists described the influence of certain work settings on their way of working with clients with the concept of efficiency being particularly evident for half of participants. P2 explained how her experience of private practice meant she's '*always been conscious of wanting to give clients value, for their time and for their money*' and short-term contracts mean she's '*used to working fairly concisely*', whilst P4's time in a university setting was seen as significant in her becoming '*much more focussed and brief.*'

P1 became aware of a different approach to client assessment after working for an Employee Assistance Programme (EAP):

*Once you've started to look at risk factors [drugs and alcohol for an EAP], I think that's what encouraged me to take a step on to talk about other risk factors... like, 'what's your coffee intake?'*

Significant too, were experiences during therapy leading to a change of perspective. For P3, it was her work with a bulimic client that provided an opportunity to consider diet within her practice:

*So that brought me into thinking 'goodness, how the nutritional side can affect people' because I noticed that when we got a sensible diet going... there was notice of mood change, confidence and her self-esteem grew.*

P5 recalled teaching physical activities with students leading to a change of approach in her counselling work:

*We worked on energy foods, things that would keep our energy levels sustained... so it was through that... I thought 'this is working for the teaching side of it'.*

In terms of growing as a practitioner, references to the benefits of maturity were also made, explained here by P3:

*I think as you get older and the more you practice... I have become more and more direct and immediate and I think that goes with confidence because you're meeting the same thing...*

### **Attitudes to therapy**

In exploring attitudes to client work, half of participants expressed a wish to best serve their clients by not limiting themselves to one theory. An example of this attitude is presented by P5:

*I'm always looking at things from a different perspective and angle... because it's not, sort of, set in stone, is it? I like the freedom to be able to move around and look at different theories and therapies.*

4 out of 6 participants described a desire to tailor their approach to accommodate clients accordingly. P1 illustrated it thus:

*What I feel I do is lay a smorgasbord in front of [the client], of thoughts and concepts and ideas... so that we're creating for [the client], it's not one size fits all.*

P6 explained how her knowledge of evolutionary biology enables her to tailor her work with men who sometimes may struggle with emotional expression:

*If I'm talking about evolutionary biology techniques and describing a troupe of chimpanzees then they can often understand that quicker and feel much more comfortable with the explanations... I learned more about people doing evolutionary biology than I ever did doing psychology, I have to say.*

All therapists described a pragmatic attitude to therapy. P4 called herself 'a pragmatist', elaborating that she will 'go for what's best for my client... offer a pragmatic set of things.' This approach was echoed by P6, who described exploring 'practical stuff', that attending to dietary habits 'gives people something to concentrate on', and that 'it's often quite useful

when you feel lost in a sea of depression or anxiety.' P2's pragmatic approach included her view of non-directive therapy:

*It isn't just self-exploration... that has a place but I tend to be more pragmatic than kind of just keeping it in say, a person-centred area session after session... for the most part I tend to be more directive.*

For P1, hearing of a client's mental health symptoms being connected to his physical health, lead to a pragmatic conclusion:

*It was discovered that he had a brain tumour... in my mind for the future is, 'don't therapise a tumour'... So partly for my assessments with people is, let's clear the decks of any possibility of there being a physical cause for what's going on for you here.*

A holistic viewpoint was evident for half of the participants and encapsulated here by P5:

*With the food and nutrition, it's all part of the whole thing really... you can't divide one from the other... [Holistic's] the word I use when I think about counselling.*

### **Therapists' aims in therapy**

In trying to identify their aims in their role as therapist, 2 participants spoke of getting to the root cause of a client's problems. P5 explained:

*It's all about knowing where your problems might arise, you know, 'is it a stress factor, is it a dietary factor, is it a lifestyle factor?' and working through that.*

This idea was comparable to the notion of solving a puzzle described by 4 out of 6 participants. P3 spoke of 'looking for clues... what it is that's affecting them most'. P6 employed a metaphor, 'we're all like jigsaws', referring to 'bits of information from clients' and storing them 'until I've got enough to make a pattern'. P1 also worked with this metaphor and that her aim when clients bring such a puzzle 'is going round the pieces of the jigsaw and going, 'well, this one doesn't quite fit there, let's have a look at it'.

Also expressed by half of participants was an interest in the idea of client empowerment. For P2, the exploration of diet and self-care was a 'necessary' process of education, 'raising awareness' and providing alternatives for the client. Further to this was P2's concept of long-term coping, getting clients 'to a place where they can self-sustain'. P6 described her

intention to enable clients to *'feel better about themselves and to help them realise that they have more control over their lives than they think they have.'*

### **Maintaining the therapeutic alliance**

All therapists expressed considerable understanding of the necessity of a supportive therapeutic relationship. Working with clients around their food intake was understood to require sensitivity. For P3, it was crucial to her that she always allowed sufficient space for her client's narrative before any kind of intervention:

*There was a big story to go through before we started tackling specific changes in diet and nutrition; I needed to hear the story first...*

Similarly aware, P6 provided an example of tentative exploration:

*'What about eating, do you eat well?' ... and then depending how they pick up on it, you know, I'll decide what I'm going to do... if they don't see it as an issue there's certainly no use forcing it on them, you have to look for avenues.*

Patience and empathy were captured by P4 in her notion of being *'alongside and if they're ready to work with it then they'll be ready to work with it.'* P2 was also keen to not create defences in clients:

*If they seem irritated or whatever, I'm not going to persist, I will drop it instantly. ... I just don't wanna alienate them at the first session.*

Examples of unconditional positive regard were also given. P5 explained, *'if the client doesn't want to do it, then that's all well and good, you have to respect that'*, an attitude mirrored here by P1:

*I mentioned this [dietary] theory and he said, 'that's absolute rubbish' and I said, 'that's fine' and then changed the subject... he lacked confidence and I was trying to show him that whatever he thought was good, was good.*

### **Client responsibility and collaboration**

When describing their engagement with clients regarding their dietary habits, 5 out of 6 participants expressed a preference for clients to take responsibility for their process,

entering into a collaborative partnership. Whilst P5 expected 'homework' outside sessions, P2 emphasised the notion of teamwork:

*My ethos is very much to help someone to help themselves... 'we're a team, I can help you with this but, you know, what's your part?' So, I don't shy away from the collaborative nature of what needs to go on.*

P3 outlined a reluctance to 'set out a diet for them' seeing it as overly prescriptive —'I always say to them that, 'I can help you but you're going to be your own detective in this.' P1 was equally clear that she did not wish to do the work 'for' the client:

*It's not what I'm gonna do for you, it's what am I going to help you to do for yourself... I say to people, 'go and look this up online, please don't take my word for it ...I don't want to spoon feed'.*

Clients' avoidance of responsibility or engagement was considered significant for half of the participants. P1 described how she understood this behaviour to be indicative of a lack of readiness to change:

*It's a very useful indicator, you know, if I'm talking to somebody about their coffee intake and their water intake and their junk food and then the next week they come and it's identical, it's like, ok, that tells us... that tells us a lot, doesn't it?*

A sentiment shared by P5:

*I won't even sort of say, 'I see you didn't [make lifestyle changes], do you want to tell me why?' because I think, 'well, it's obvious isn't it? ... They don't want to help themselves... they prefer things the way they are.*

### **C. Diet and nutrition within the therapy process**

#### **Assessing clients' presenting issues**

Participants illustrated a wide range of ways in which a client's diet/nutritional intake might be taken into account alongside their symptoms during the therapy process. P2 spoke of how, at assessment, she would ask about 'nutritional intake and how healthy it is' if clients showed 'aspects of mood disorder', whilst the impact of caffeine and other substances was of particular interest to P1, especially when considering symptoms of anxiety and depression:

*...again this is where we come back to the nutrition... I now ask everybody about their coffee intake, their tea intake, their sweeteners intake and fizzy drinks... I mean one lady was having 20 coffees.*

Similarly, the impact of caffeine was of interest to P4 when addressing sleep problems and anxiety:

*If we decide that [panicky clients] are thinking these thoughts at night and they're also having lots of caffeine... we might be talking about, 'are you, you know, drinking Coca-Cola or having coffee and tea late at night?'*

The connection between unstable blood sugar and mood was highlighted by P6's depiction of hunger leaving some people 'unable to cope', whilst P3 recognised the stimulant and withdrawal effects of caffeine and sugar:

*Getting snappy, angry, cross... they get like that when they've missed a cup of coffee or two. Or their sugar bar... whatever it is that has been actually keeping them, in their words, calm.*

The issue of a client's diet was also described as significant to the bigger picture. P5 illustrates:

*Someone will come to you with a problem that's obviously very important, but if... they're not eating right or sleeping right, then it's added to the problem 10-fold.*

P3 showed a similar holistic understanding:

*If there's an emotion that you can't really link to something else they're telling me in their story, it's just listening out for behaviours... maybe linked with diet and nutrition...*

### **Exploring diet as part of lifestyle and self-care**

5 out of 6 participants explained how they might work to gain a broader understanding of a clients' lifestyle and levels of self-care, including dietary habits. A standard university assessment form enabled P4 to ask general health questions:

*...there are 3 questions about appetite, diet and weight... they're coming mostly with emotional or mental health problems and then you would be asking, 'what's your health like?'*

Half of participants expressed an interest to assess general lifestyle factors that also included exercise. P2 would follow exercise questions with nutritional enquiries regarding 'veggies,



fruit, what would they normally eat' as well as 'do they tend to eat a lot of fast food?' For P5, working with clients with sleep problems indicates a need for lifestyle and dietary exploration:

*...you have to work on what exactly is happening, 'what are you eating before you go to bed? What are you eating in the day to keep your blood sugar levels?' You know, 'how much exercise do you get?'*

P6 described working through lifestyle factors as possible options for clients and included diet:

*...things they can do... 'oh, do you like exercise?' or 'do you like reading?' or 'what about eating, do you eat well?'*

P3 placed emphasis on the time taken for oneself along with diet and nutrition in her assessment:

*What's their day like? Have they got time to sit? Have they got time to eat? I wonder what they're eating?... I look at how they're affected in their lives [in] a physical and emotional and behavioural way...*

### **Use of dietary intervention**

Participants demonstrated a variety of ways in which they might explore diet with clients. For example, therapists might discuss specific foods beneficial to health. Highlighting the benefits of serotonin and tryptophan-rich foods for depression, P5 illustrated how she might explain this to a client:

*...if there was too much refined foods, looking at foods that, you know, boost serotonin, tryptophan... I'd most probably say, 'have you looked at your diet and do you know that certain foods can have a chemical reaction, as can medication?'*

P2 echoed this approach:

*'Let's look at what you're doing to try and help yourself, you know, tryptophan is something that helps your serotonin levels... bananas... would you have some yoghurt... brown rice?'*

Educating clients about the need for healthy fats was illustrated by P1 who would pass on information about omega 3 oils through 'some Udo's oil leaflets' that she might hand out. P2 would offer a brief explanation:

*...you know, 'do you realise that such a high percentage of your brain cells are actually coated with fat and the cells, if they can't get the right kind of fat... get misshapen and the electrical impulses can't travel as efficiently'.*

Information regarding blood sugar levels might also be shared with clients. P4 would explore maintaining energy levels with clients:

*...'how many meals a day are you eating?... use crude analogies like, 'you wouldn't expect your car to go from A to B with no fuel in its tank so why do you expect to get through the day and study... and use your brain without any fuel for your body?'*

P3 was often interested in a client's sugar intake, and would explore the consequences of snacking on sugary foods:

*...you're not eating and you pick up a bag of sweets or a bar of chocolate... not long [after], let's say half-hour to an hour, feel really sink-y?*

P4 understood the potential benefits to eating in a social context - *'the reparative effect'* of *'the social aspect'* of eating:

*...for some students who are lonely or they're over-working, you know, like one's anxiety about one's course... it's really important to just go out for a meal. '*

Various tools were also used in interventions by participants. P3 spoke of suggesting a food diary to clients to *'find out what you are eating and when you are eating'*. Similarly, P5 would use the information collected on *'a diet sheet as part of the counselling'* to discuss the impact of diet on a client's mood. P1 described how the use of diagrams was helpful in illustrating the effects of sweeteners:

*...you get a blood sugar spike, insulin kicking in to bring it back down and then I would draw a diagram of, you know, these spikes going up and down and then always they go, 'ohhh, is that why I feel...?'*

### **Client responses to interventions**

A variety of client responses to dietary interventions were reported, with all participants telling of positive outcomes for clients. P2, based in a university, described how some clients went on to take more care to prepare their food, avoiding unhealthy snacking:

*...they're now preparing lunches and bringing little lunches with them to campus ... and put almonds in their bag if they're snackish rather than always having that chocolate bar.*

A client's allergies were identified after a recommendation by P4:

*I said, 'well, it sounds like you've got some allergic reactions to the food... why don't you go to a nutritionist... and she sent me a card later saying, 'I've found out I'm allergic to this, this and this and I'm much better if I've avoided those foods.*

Working with bulimia, P3 collaborated with her client to achieve a more balanced diet with positive results:

*...she then wasn't craving... if she kept to a diet like that then she wouldn't binge and wouldn't want to make herself sick, and you see [bingeing] made her feel bad about herself, so there was a link with the self-confidence and self-esteem.*

With P1's support her bulimic client removed the use of sweeteners and then re-introduced them to test the theory:

*2 or 3 weeks later she said, 'I thought I'd just have a trial to see... what the sweeteners were doing' and had a day of some sweeteners again and the bulimia was right back in place.*

All participants, however, also reported defensive responses from clients. P5 observed that clients can become agitated when faced with the idea that their physical health may be a factor in their mental health:

*They think it's all about, you know, the mind and you can sense the tension and the anger and the frustration with a few of them who come in and think it's all about the emotional side and nothing else.*

Other clients might behave more passively. P5 described a client who seemed to feel it was easier to 'just stick to the medication', whilst P4 observed some clients 'to be conscious about caffeine' but who go on to 'totally ignore it and ignore the need for sleep.'

P2 spoke of some clients for whom dietary change is 'non-negotiable' and 'just won't eat a vegetable'. P3 also described resistance:

*You're stood on your head, done everything and there's no way they're going to change... even if you take a tiny aspect, they still don't change.*

## **D. Considering ethical practice**

### **Working with competence**

All participants made references to attempts to work with competence when addressing issues of diet/nutrition with clients, although half of participants had undertaken formal training enabling them to work appropriately with diet and nutrition with clients. For example, P6 spoke of caution when approaching a client's diet as she *'could be completely down the wrong track'*. This was an insight shared by P3 describing it as a potential *'minefield'* and that *'you can get it wrong... if you go straight in with food and diet'*.

Of particular concern was being able to recognise one's professional limitations and P1 was keen to point out to clients that nutrition was secondary to the counselling process:

*... 'this is now counselling, please go and research that yourself, please go and consult with your doctor, consult with a nutritionist', you know, I'm not saying I'm an expert.*

P1 also went on to make specific reference to ethical guidelines in her practice:

*I'm very keen on BACP guidelines on maleficence... I've said to people, you know, 'my code of ethics says that I'm not allowed to harm you so we're not gonna go there' or 'we're not gonna do that'... I would laugh about it but I do take that very, very seriously indeed.*

When speaking of making suggestions P2 also added that she was *'not a doctor, I'm not prescribing'*. P5 mirrored this care in her approach to advice:

*...if someone came and I said, 'oh, why don't you take some B vitamins for your nerves?' I would never dream of doing that. I don't know what their medication is.*

Other comments related to the importance of attaining a qualified opinion. P4 said that she would not *'claim to be an expert'*, and would recommend appropriate consultation. P5 made this observation:

*Anyone that takes St. John's Wort, it can have an effect with medication... so always check it out with your GP, or your practice nurse.*

P1 highlighted another source of nutritional reference quoting the Institute of Optimum Nutrition who 'recommends 2 spoonfuls of seeds'. Akin to this, P5 described the requirement for continual learning through research:

*You've always got to... I'm constantly doing research around... food and nutrition.*

### **Socio-economic issues in diet and nutrition**

4 out of 6 participants made reference to socio-economic issues. P2 spoke of her experience of students from different economic backgrounds when exploring diet and potential limitations of social class when exploring dietary habits:

*[The lack of healthy eating habits] did seem to be the level of... I don't know, deprivation that they grew up in... I would definitely say that there's a level of, sort of, education and some of the social class side does feed into that... some of those students, who've come from more privileged backgrounds... it's almost such a no-brainer, the [healthy] habits were entrenched at such an early age.*

Participants were aware too of the financial implications for clients of eating well and affording specific healthy choices. P2 spoke of clients who would perceive 'decent food' as too expensive 'living on such a tight budget'. This was echoed by P5, who's client could not 'afford to buy, you know, green tea' or whatever.' Commenting on the price of blueberries, P6 said, 'yes they are good for you but they cost 4 times as much as something else that's just as good for you.'

For P4, her students' financial situations often posed dilemmas when wishing to recommend alternative consultations:

*The trouble is... that the National Health, very few people are trained in nutrition. So I would be saying, 'if you've got some money at some point... you could go and see a nutritionist'.*

### **Awareness of own process as therapist**

Half of participants spoke of their part in the process when working with clients' diet.

Reflecting on the therapy dynamic, P3 explained:

*I'm very strong on transference and counter transference, I must say... when I'm working with someone... often it triggers things in me... my own experience of emotional eating, definitely.*

Using such awareness, P3 also recommended exploring difficult client encounters more fully:

*You have to take that back and think, 'did I push? Was I banging on too much about nutrition or something?'... and analyse it and reflect on it and wonder.*

P2 shared how the research interview itself had brought a chance for her to consider her practice:

*Seeing your questions was certainly a pause for reflection on something I probably haven't thought about for a while because I've just, kind of, got into a flow of 'this is how I do it'.*

Referring to her own agenda in her way of working, P4 recognised that it included her 'personal interests' and her own 'personal values.' This issue was pertinent for P3 too, explaining:

*Remember, they don't come in specifically for the diet or nutrition, that's just the way I work.*

### **Experience of supervision**

All participants attended regular supervision, though experiences of discussing dietary issues during supervision varied. For half of the participants, supervision provided a creative space for discussion and sharing of knowledge. P3 described her supervisor as 'very good' and able to discuss 'what happens within the body that often does link into diet and nutrition'. P6 spoke warmly of her supervisor, 'we do a lot of peer supervision' and they agreed that 'food is a very important issue.' P5 reported the positive feedback of her supervision group:

*Usually when we're discussing it in a session, other counsellors are saying, 'ooh, that's a good idea, I might try that me self!'*

Slightly differently for P1, she concluded that whilst her supervisor didn't address nutritional or dietary issues within her own practice, she remained respectful of P1's perspective:

*My sense is that she doesn't do it to the extent that I do, but [would be] on board with the idea that that would be, you know, a good thing.*

However, 2 participants felt that their dietary work with clients went unheard in supervision. P2 described that *'in fact it's very rare that I get a chance to bring it up in supervision'*, due to a supervisor who *'stays very much in her model'*. P4 said too that:

*I don't get that much response, if I'm honest... I don't feel like it's a dimension that's really opened up.*

This chapter has presented the master themes and themes as drawn from the data, with quotes from participants to provide illustration. These findings will be discussed, with implications for practice, in the following chapter.

## **Chapter 5: Discussion**

This study sought to explore how counsellors and psychotherapists understand diet and nutrition as part of the therapeutic process. When considering the findings, it is apparent that there are many areas of influence and consideration for each therapist at various times during therapy, with varying degrees of focus and emphasis. The wide range of responses also illustrates the potential for different meanings and interpretation when considering food, even in a homogenous sample such as this.

A number of key points emerged throughout the analysis including: the impact of personal views and lifestyles of the participants on their subsequent use of dietary knowledge; the notion of how to best serve a client's needs during therapy; relational issues in applying dietary knowledge; providing optimum therapy for positive outcomes; and maintaining best practice. These areas were incorporated into the 4 master themes, as developed from the data, which will provide the basis for the following discussion. The researcher's reflexivity will then be revisited, plus implications for practice, identified limitations of the study and areas for further research.

### **Personal aspects of the therapist**

It is generally understood that life events shape an individual's perceptions and their expectations of the world; that experience enables the creation of links and development of meanings. When a particular issue or event is deemed to be of particular relevance or importance for a person, this understanding is often influenced by the importance or significance that it holds due to the person's previous experience. When considering the results of this study, it would seem that this principle may also apply to the use of particular approaches to client work.



For this particular group of therapists, their personal histories and lifestyles were significant and important factors in shaping understanding of the relevance of diet and nutrition for an improved life and well-being. All participants disclosed some type of personal connection to food and nutrition, whether this was experience within their family unit over their formative years or experiences later on in adult life that highlighted the role of food in caring for oneself and maintaining health.

These findings would support a previous study by Royak-Schaler and Feldman (1984) which concluded that therapists were happier to recommend activities for well-being to their clients that they were personally familiar with and already part of their own lifestyle, further highlighting that a belief in what 'works' may often be bolstered by personal experience of success. The experience of the researcher also supports this.

4 out of 6 participants shared observations concerning the attitudes and provision of nutritional support by GPs and the NHS, supporting the findings of the Associate Parliamentary Food and Health Forum (2008), that nutritional support and advice offered by GPs and medical staff is often inadequate. Therefore, therapists would often go on to consider alternatives with clients, judging there to be an absence of any effective support or intervention from the medical field.

### **Therapeutic approach and philosophy**

The personality of the therapist seemed pertinent here: the level of personal and professional development of the therapist encompassing their attitudes and beliefs about the process itself. The notion of working at the root cause of a client's problems and 'solving the puzzle' was highlighted by 5 out of 6 therapists; that it was desirable to understand as fully as possible the origins of a client's problems, as well as seeking a long term management of it.

This type of pragmatism was an attitude emphasised by all 6 participants in their approach to therapy, indicated not simply by the choice of therapeutic tools and interventions deemed available, but in a more comprehensive sense – that a client's well-being is not solely a case of psychological distress – that other factors potentially cause or exacerbate the presenting symptoms and need to be addressed as fully as is possible or appropriate.

Efficiency was also highlighted for 3 of the 6 participants. In working with a client's attitudes to diet and self-care within the wider context of the client's growth and development potentially means that all avenues toward increasing the client's chances of improvement are explored. Significantly, it was evident that the therapist will not always assign themselves to the task of dietary intervention within their role but may simply signpost the client to another qualified professional, echoing the recommendations of Lewisham Counselling and Counsellor Training Associates (2011) and Adams, Minogue and Lucock (2010).

Illustrations of efficient and pragmatic approaches to therapy were often accompanied by a sense of the practitioners' maturity. For the experienced therapists of this study, it seemed there was an appreciation that life is not 'straight forward' and that a certain 'preciousness' around theoretical issues was reduced; that theory serves an important purpose but doesn't override other senses when making decisions about a client's interests or opportunities for wellness. They understood that certain clients may need different things at different times and adjusted their practice accordingly, seeking the best solutions for clients by employing what they had learned through experience.

These pragmatic and mature perspectives resonate with the findings of Rønnestad and Skovholt (2003), concerning the professional development of practitioners and recognised the phases that a practitioner will move through during their career. They identified a certain type of flexibility that occurs at the *Experienced Professional Phase* (p. 20) as a result of encounters with many clients, a range of work settings and life itself. This personal and

professional development meant an increased confidence to take risks in therapy and challenge set theory, with no loyal alliance to one particular school of thought; that to achieve desired goals in therapy may sometimes require a different perspective and possibly even a degree of risk.

Alongside creativity, risk and practicality however, was the understanding of clients' responses to interventions and being aware of these at all times, attending to the therapeutic alliance. Providing the client with sufficient space for their presenting issues, proceeding with sensitivity and caution, and respecting a client's views on the subject were reported by all participants, illustrating clearly an awareness of the necessary conditions for successful therapy and not being seduced by one's own agenda.

Improving a client's well-being was also understood in terms of empowerment by half of the therapists, with an important aspect of this being the provision of information, equipping them for better self-care, and exploring the notion of alternatives and choice available to a client in their life. Akin to this perspective was the importance placed on a client's responsibility for self and engagement with their process, indicated by 5 out of 6 participants, again suggesting a more mature perspective and realistic expectations of therapy.

### **Diet and nutrition within the therapy process**

The notion of viewing a client holistically was a key factor for therapists. All participants seemed aware that the whole of the client was important when considering their psychological problems. At times, participants would understand their client's psychological symptoms in terms of the physical and biological, taking into account diet and nutritional issues. For example, it was understood that certain inadequate dietary intake or eating patterns can lead to irritability, anxiety, fatigue or sleeplessness, reminiscent of the points made by Holford (2004). In the application of a balanced diet and lifestyle, reduced engagement in destructive eating habits associated with disordered eating was also

highlighted, and similar to the speculations of Weidner et al. (2009) was the idea that clients' confidence and self-esteem may be improved in achieving of such eating behaviours.

The ways in which each therapist would approach diet and nutrition with clients would vary depending on formal training and the emphasis they placed on the importance of diet and nutrition within their work. A simple way of considering the variety of interventions can be considered along a spectrum, as outlined in Figure 2.

Figure 2: Spectrum of Dietary Interventions

*Removing problematic substances*

*Adding nutrients/beneficial foods*



It would seem that in terms of dietary interventions there is a continuum: from the removal of problematic substances, e.g. in terms of clients with intolerances and allergies; consuming less unhealthy processed foods; avoiding high sugar, high processed fats, caffeine or sweeteners; to increasing the intake of more healthy and helpful substances, e.g. fruit and vegetables; water; foods with a low glycaemic load for more steady blood sugar; vitamin and mineral supplements and essential fatty acids.

Participants also used dietary interventions to learn more about their clients and this occurred in several ways. Whether making health, lifestyle or diet related enquiries at assessment or engaging with information about a client's diet later on in therapy, therapists saw these enquiries as opportunities to acquire 'clues', informing the overall therapeutic process.

Clients' dietary behaviour was often seen as indicative of an ability or willingness to care for one's self, with a client's approach to diet explored within the more general context of lifestyle, for example, including other factors such as exercise or taking the time out to

nurture oneself. Additionally, the symbolic nature of food was highlighted, that food itself can have less obvious meanings such as an indicator of control or safety. Making more specific dietary enquiries also enabled therapists to speculate about the possible physical causes of symptoms.

Clients' specific responses to enquiries or interventions provided important indicators for therapists. Positive responses from a client, for example, displaying interest in the ideas or reporting beneficial changes made to their diet or lifestyle would be an affirmation for the therapist, rendering it a feasible option for future clients. Conversely, a client's defensive response to the diet and lifestyle perspective, often understood through a client's defensive body language or dismissal of subject, would usually suggest a necessary change of direction - to couch the dietary exploration in more appropriate terms, postpone it or simply cease altogether.

Clients' lack of engagement in making changes to their lifestyle or diet was understood in a variety of ways, depending on the therapist. For some, it was simply a case of waiting for the client to engage when they were ready; at times other therapists interpreted this as a sign that clients may not actually be as ready to make changes in their lives as they had initially communicated or they were lacking motivation to make changes in their lives.

### **Considering ethical practice**

All participants expressed an interest to remain aware of their limitations when addressing dietary issues with clients and it seemed that though all participants held a passionate interest in dietary issues, there was a tentativeness also expressed through deference to a more qualified opinion. For two participants in particular there was an explicit recommendation of caution when pursuing a line of inquiry, that to avoid inaccurate assumptions a degree of patience may be required.

In advocating a healthier lifestyle, issues of a socio-economic nature were raised by four participants. Whilst it does not necessarily follow that a healthier dietary choice means one that is more expensive, a client in session may certainly perceive it as such, a point recognised in the study by Jorm et al. (2000), and may have implications for the therapist-client dynamic. Perceived class differences between therapist and client, raised when assumptions are made about a client's ability to afford food, nutritional supplements or consultations, can impact on the working relationship if not attended to with care. Issues around what is affordable for either party become pertinent, especially if the therapist is deemed to hold the 'higher' social status, providing the client an opportunity to nurture fantasies about the therapist's own income or lifestyle choices.

A participant also raised the issue of a class divide in terms of nutritional knowledge: that clients from less privileged backgrounds may have had less exposure to dietary or nutritional information as part of their lifestyle or indeed less availability of economic resources. It seems to be another area that warrants consideration when addressing such issues; that such an intervention exists within a social and cultural context.

When engaging in therapeutic practice, the self-awareness of the therapist is crucial. The therapeutic relationship, like many other aspects of the therapeutic process, is informed by the person of the therapist – their personality, appearance, values and beliefs – all will exert a degree of influence. The factors of our own experience and how they may be at play in encounters with our clients merits continual exploration.

An awareness of bias, due to the therapist's own lifestyle choices or pursuit of health when exploring diet and nutrition with clients, is an area that would ideally be explored in supervision. However, whilst half of interviewees reported positive support from their supervisor, it seems that participants' experience of supervision was varied and did not always provide a suitable arena in which to conduct such exploration. One participant

explained her supervisor's lack of engagement with issues of diet and nutrition in terms of the supervisor's choice of psycho-analytic model, highlighting the matter of theoretical stance when engaging with clients in this way, an issue raised previously by the findings of Burks and Keeley (1989).

### **Revisiting reflexivity**

The conclusion of the last participant interview was followed by a repetition for me of the interview process, in an attempt to elucidate my own perceptions and beliefs regarding diet, nutrition and therapy. Now inhabiting the *Illumination* phase of heuristic inquiry that sees new insight or 'corrections of distorted understandings' (Moustakas, 1990, p. 29), I 'felt' the wide range of perspectives and array of influential factors illustrated by my participants now enhanced by my own interview experience.

From my initial research concern - therapists' dietary interventions and methods of application during therapy with clients - it now seemed more pertinent to explore how they had arrived at their particular viewpoint and understanding, as well as how they used this information: What perceptions are held by therapists working this way? What value systems might be in place during therapy and what personal contexts and histories might be involved when understanding and assessing a client's problems? This change of focus also moved my study further in line with heuristic intention: 'heuristics is concerned with meanings, not measurements... quality, not quantity; with experience, not behaviour' (Douglass & Moustakas, 1985, p. 42).

Conducting the interviews for both the participants and me proved to be a powerful experience that has had a significant effect upon my personal and professional life, finding much of my participants' experience and approach to therapy to resonate strongly with my own. As a practitioner with 12 years of experience, I too would be placed within the *Experienced Professional Phase* (Rønnestad & Skovholt, 2003); assessing my theoretical

stance and philosophy when considering my aims for my clients' well-being, taking a broader perspective and feeling no obligation to commit loyally to a solitary theory. I feel an acute awareness that my belief in the importance of addressing diet and lifestyle during therapy is also not only rooted in the research and literature, but in my experience of improved health and continued well-being.

Due to the research process, notably exploring the existing literature and internet resources, I am now acutely aware of the wealth of materials available that provide accessible information on diet, nutrition and mental health. These tools mean that when client interest and motivation are evident during therapy, I feel equipped to signpost alternatives for further exploration. The simple existence of such resources provided by reputable sources such as Mind, The Mental Health Foundation and NHS trusts, delivers not only practical support in my work, but a sense of affirmation in my aims for my client: providing an avenue to increased health and effectiveness in their lives, through understanding how their mental health may be affected by their diet and lifestyle.

I am currently in the process of understanding how to most effectively incorporate such tools into my practice and their place within my philosophy as an integrative counsellor. Since this study's undertaking my client assessment process has extended to include an exploration of clients' day-to-day lifestyle, preferred dietary habits as well as their work life and methods of self-care. Clients' responses at this stage also enable me to gauge the potential to address such issues, including diet if necessary, as indeed such issues may not be apparent for the client at all. Ultimately, I recognise what the *client* wants to be imperative – I see that this is my guide; in my role I will offer what I feel I have learned in order for them to choose what will be most useful to them at that time.



## **Implications for practice**

The literature and participant accounts provide many aspects for further consideration in our practice as therapists. McLeod (2001) highlights that in our field much of the research is difficult for practitioners to link to their actual practice and sees a need for more research to be 'tied to practical action rather than open-ended theorising and speculation' (p. 202); this observation has influenced both this study and the following suggestions.

The Associate Parliamentary Food and Health Forum (2008) listed amongst its findings a less than satisfactory standard of training and nutritional support for patients by GPs, calling for this issue to be addressed by the Royal Medical Colleges and the General Medical Council. Participant comments echoed this report's findings - that nutrition and diet were inadequately catered for by the average GP and difficult to access through an NHS service. In the light of such conclusions, it seems inaccurate then to assume that a client's diet will always be fully addressed by a client's GP with clients potentially bringing unresolved issues to therapy.

There appears to be a wealth of information available to interested practitioners with which to engage and educate clients, provided by established mental health organisations and nutritional experts. Whilst attempting to map out a client's diet, or advising on specific supplementation without sufficient qualification is not recommended by the researcher, the avoidance of a prescriptive approach may not necessarily preclude suggestions or exploration. As reported by participants, some clients may prefer a natural approach to health and avoid taking medication - understandable when considering the side effects of many drugs, including anti-depressants. It would seem that a multi-disciplinary approach and a willingness to involve another suitably qualified professional may make it be possible for clients to be supported in their choice. However, as raised by the study of Caldwell and Jorm (2000), it needs to be remembered that not all of the professionals involved in a client's

mental health care will necessarily support or further the initiatives taken by practitioners engaging with issues of diet and nutrition.

In working toward increased awareness and integration of diet and nutrition into therapeutic practice, practitioners may need to source an adequate range of relevant information. This may require commitment and effort, but ultimately it would enable a practitioner to be aware of the latest information and developments in this area, and be equipped to signpost clients toward appropriate resources. Then, in the same way that excessive alcohol consumption or recreational drug abuse might be explored in session, client's mistreatment of their body with more socially acceptable substances - caffeine, sugar, fat or junk food - might also be highlighted when understood to be having an unhelpful physical impact on the client's well-being.

When bringing dietary ideas and information to the therapy dynamic, it would seem the process becomes more complex than a non-directive encounter, with many factors in play from one meeting to another. The complexities of working in this way are myriad, with food and drink existing in social, political and cultural domains of human life as well as the biological and psychological (Adams, Minogue & Lucock, 2010). Therefore, it must be remembered that any dietary intervention holds the potential for hidden meaning, judgement and assumption. As practitioners we often provide modelling for clients and it follows that during a dietary intervention clients may assess the lifestyle and eating habits of the therapist based on physical appearance, such as weight or pallor, colouring the intervention.

In addition, some clients may find the notion of altering deeply engrained eating habits anxiety provoking, having thus far secured comfort, escape or social contact in their lives through food and drink. Therefore, the appropriateness of interventions is best assessed on a client by client basis, with vigilant attendance to the therapeutic alliance. An awareness too

of realistic changes for clients is pertinent, with research showing that cheap and accessible interventions are more likely to be carried out by clients (Jorm et al., 2000).

Furthermore, complex psychological and emotional processes also exist for practitioners. As this study shows, a client's relationship with food may trigger reactions within the therapist, especially if related to the therapist's own relationship with food or perceived as a client's method of self-harming. Such complicated dynamics highlight the need for acute awareness of what it is we bring as therapists to the therapeutic encounter - our agenda during interventions with clients and an acknowledgement of the risk that at times we may push aspects of our own belief system onto a client. A supportive environment to explore these issues is important and supervision with a practitioner who is also appropriately informed seems to be key. The provision of appropriate space and challenge within supervision groups might also serve such a purpose.

Before conducting this study, despite an avid interest in this area, this researcher was not aware of specific nutritional training for mental health being available. It seems that the development or promotion of such courses remains scarce, despite training by nutritionist Kevin Williamson being devised for the NHS in 2009. Promoted as continued professional development, many more courses need to be designed, with the aforementioned areas fully considered in order to provide therapists with the best chances of working successfully with clients. Counselling and psychotherapy training courses might also consider introducing diet and nutrition modules into trainees' education.

To further best possible standards, it would seem that more support from counselling and psychotherapy professional bodies is also needed - practice guidelines, fact sheets, on-going research in this area highlighted and discussed in journals - all this would contribute to diet and nutritional issues becoming more integrated into the field. This integration might also involve linking with other professional bodies within the field of diet and nutrition.

## **Limitations**

Due to the small scale of this study, it was only possible to consider a maximum of 6 accounts. All participants were self-selecting and in order to meet the study's aims were individuals with an existing interest in this area, thereby neglecting the opposite view. Further to this, others with an interest in this area may not have responded to the advert, possibly lacking confidence or reluctant to discuss what may be considered an uncommon approach to therapy. The telephone interview method may have also limited the data gathered: potential participants may have been deterred by a faceless interaction as well as more subtle communications between researcher and participants being missed due to the lack of visible body language. All participants were female and can be regarded as experienced practitioners; holding a minimum of 12 years' experience, the average length of career was 27 years in the field, leaving no opportunity to consider the views of male practitioners or those with less experience. Also, all practitioners practised an integrated or eclectic form of therapy meaning that the views of therapists from other theoretical orientations were not explored.

The heuristic method, a key aspect of the research, can also be assessed in terms of limitation. In using the researcher's Self as part of this work, the perceptions and interpretations of accounts will be assessed in terms of her personal history, beliefs and prior knowledge (Etherington, 2004a).

## **Further research**

It is evident that the study of diet, nutrition and mental health is gaining momentum, with ideas and recommendations for the incorporation of diet into recovery or maintenance of mental health symptoms now being discussed (Adams, Minogue & Lucock, 2010; Associate Parliamentary Food and Health Forum, 2008; Lewisham Counselling & Counsellor Training Associates, 2011; Pointon, 2006). However, whilst a wealth of information on the links between diet, nutrition and mental health issues exists, it would seem that the research into

the actual practice of incorporating such issues by the therapists themselves – an area addressed by this study – remains scarce.

Further research is required into the issues for therapists entering into this type of working and seems invaluable to the development of diet and nutrition training for therapists. As well as the application of assessments or interventions, the potential challenges and dilemmas such therapy may present need to be better understood: the impact of client and therapist characteristics - gender, age, class or ethnicity; the personal beliefs of both therapist and client around weight and physical appearance; the clients' experience of dietary exploration and importantly, the effectiveness of such interventions. With this information therapists would then be equipped to address clients' responses appropriately, understanding the symbolic as well as biological nature of food and nutrition.

## **Chapter 6: Conclusion**

This study set out to explore the understanding of counsellors and psychotherapists – their perceptions, values and beliefs - when considering issues of diet and/or nutrition within the therapeutic process, including the ways in which this understanding is applied during the therapy process with clients.

In consulting the literature, it is evident that a variety of studies into the physical and psychological connection with diet and nutrition have been conducted, though conclusive evidence for the beneficial impact of particular foods or nutrients is currently limited. However, there also exists a wide range of materials provided by mental health organisations illustrating the ‘food and mood’ connection, with advice on how to manage food and drink; dietary patterns and vitamins and mineral intake to reduce mental health symptoms.

The interviews with participants highlighted many issues for further consideration when working in this way: the impact of the therapists’ life experiences and subsequent personal belief systems; working efficiently with clients whilst attempting to meet their needs as well as maintaining best practice and ethical standards. For all participants the safety and well-being of the client was paramount with emphasis placed upon the maintenance of the therapeutic relationship, working sensitively when approaching the issues of diet or lifestyle. In addressing such issues with clients, a pragmatism and efficiency was also apparent, reflective of participants’ life experience and maturity, with an emphasis to provide the best chances of recovery for the client.

Half of the participants had undertaken formal training advancing their understanding of nutritional and dietary issues and, enabling them to apply such knowledge during therapy. For other participants however, knowledge acquired through personal research, exploration and client experience were their points of reference. It would appear that therapists

interested in developing this approach to therapy may be limited in accessing the appropriate training, with such courses seemingly scarce.

When accessing supervision, experiences of exploring diet and nutrition with clients were reported to be supportive to varying degrees, with only half of participants reporting full constructive support. This is significant in terms of professional development for practitioners and further research is indicated to fully understand the implications and challenges for therapists and their clients when using this type of approach.

This study was born of the researcher's interest to attain the best quality of life for her clients, with experience suggesting the need for both mental and physical health. Though currently regarded as separate areas of research and practice, in striving for the good health of clients it seems that the fields of diet/nutrition and counselling/psychotherapy may share a common interest. This study's findings indicate that the knowledge we hold within our discrete working practices and research fields may benefit from a collaborative effort, with a pooling of resources in training and education.

This type of approach is a move towards a more holistic view of clients that involves a developed understanding of a client's whole physical being, as well as the psychological and emotional elements. It also involves a shift in perception of what a counsellor or psychotherapist should or can achieve with a client in therapy. Indeed, it will present many challenges. Yet, it seems that if we are to provide our clients with the best opportunities to attain physical and mental health – and hopefully to sustain well-being - it may prove to be a progressive and necessary step for our profession.

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# ***Diet and Nutrition***

## ***in Counselling and Psychotherapy***

*As part of a Master's degree at the University of Chester, I am undertaking a year-long research project.*

***I am currently seeking qualified counsellors and psychotherapists for a one-hour (approx.) recorded phone interview to understand more about how practicing counsellors/psychotherapists may be considering dietary and/or nutritional information in their work with clients and their reasons for doing so.***

*If these issues sound of interest to you and you would like to take part or simply wish to find out more, I would be delighted to hear from you.*

**Nicola Terry, **  
**[email@nicolaterry.co.uk](mailto:email@nicolaterry.co.uk)**

*Thank you for your time.*

**Appendix B: Advert posted**

**Diet and nutrition in counselling/psychotherapy**

Counsellors/psychotherapists needed for phone interview for MA research, exploring how diet/nutrition is considered with their clients during therapeutic process. Contact Nicola Terry  
; email@nicolaterry.co.uk.

**Appendix C: Email circulated**

**Diet and nutrition in counselling/psychotherapy**

As part of a Master's degree at the University of Chester, I am undertaking a year-long research project, exploring the ways that counsellors/psychotherapists use dietary and/or nutritional information in their work with clients during the course of therapy.

Therefore, I am currently seeking qualified counsellors and psychotherapists for a one-hour (approx.) taped phone interview to understand more about how practicing counsellors/psychotherapists may be considering such information and their reasons for doing so.

If these issues sound of interest to you and you would like to take part or simply wish to find out more, I would be delighted to hear from you. Please contact me:

Nicola Terry. [email@nicolaterry.co.uk](mailto:email@nicolaterry.co.uk)

Thank you for your time.





**How Do Counsellors and Psychotherapists Consider Diet and Nutrition With Their Clients?**

*Thank you for expressing interest in this research and for taking the time to read this.*

*You are invited to take part in a study and as such it is important that you have the following information and understand the purpose of this work.*

*Please take time to consider all the points and discuss them with others if you wish to do so. I am keen to provide any further information that you may require or answer any questions you may have before you decide whether or not to participate.*

**What is the purpose of the study?**

As part of a Master's degree at the University of Chester, I am undertaking a year long research project exploring the ways that counsellors/psychotherapists use dietary and/or nutritional information in their work with clients during the course of therapy.

The aim of the research is to understand more about how practicing counsellors/psychotherapists may be considering and using such information and their reasons for doing so. As a practitioner with a passionate interest in these issues, I am keen to explore the views and experiences of other therapists in their client work.

**Why have I been chosen?**

You have been chosen because you are a fully qualified counsellor/psychotherapist with an interest in the relevance of dietary and/or nutritional factors in therapy. Potentially, you could offer valuable information and insight into this topic, enabling me to explore a range of different views in this area.

**Do I have to take part?**

It is up to you to decide whether or not to take part. If you decide to take part you will be asked to sign a consent form. You are still free to withdraw at any time and without giving a reason. Withdrawal would be possible promptly by email or phone call.

A decision to withdraw, or a decision not to take part, will be completely respected; any information so far attained would be also destroyed or returned to you as requested.

**What will happen to me if I take part?**

Your signed consent form grants me permission to contact you to arrange a time for the interview which will take approximately one hour. The interview will be conducted by phone, at a time agreed by you.

The interview will attempt to explore your views and experiences regarding client work in terms of your interest in diet, nutrition and mental health. For example, I will ask you about the ways in which you consider diet and/or nutrition as part of the therapeutic process and your reasons for this; where your interest in diet and/or nutrition originates and the possible influences in this. I am also interested to hear about the context of your client work, i.e. the type of work setting(s) you are engaged with; your theoretical orientation and the extent of

your professional practice. Importantly, your personal experience of these types of encounter is of immense interest to me and of value to the study.

**What are the possible disadvantages and risks of taking part?**

There are no disadvantages or risks foreseen in taking part in the study. However, if you feel that exploring issues around food or eating may be distressing or difficult for you, then this is an important consideration before agreeing to take part.

**What are the possible benefits of taking part?**

As a counsellor/psychotherapist with an interest in these issues, taking part in the interview could be an opportunity for you to develop or clarify your ideas about dietary/nutritional in counselling and psychotherapy.

In addition, you will be contributing to an under researched aspect of the therapeutic process which could hopefully go on to inform or evoke discussion for others in the profession or related areas.

**What if something goes wrong?**

If you wish to complain or have any concerns about any aspect of the way you have been approached or treated during the course of this study, please contact: *David Balsamo, Dean of Faculty of Social Sciences, 01244 511185; d.balsamo@chester.ac.uk*.

If you are harmed by taking part in this research project, there are no special compensation arrangements. If you are harmed due to someone's negligence (but not otherwise), then you may have grounds for legal action, but you may have to pay for this.

Should you experience any emotional distress as a result of the interview, professional support is strongly recommended and contact information is provided at the end of this sheet to enable you to do this.

**Will my taking part in the study be kept confidential?**

All information which is collected about you during the course of the research will be kept strictly confidential so that only I will be aware of your identity.

From the signing of the consent form you will be assigned a code and your personal details will be stored separately. This code will be used on all documentation in connection with you for the duration of the study and subsequent write-up.

Once transcribed, a copy of the transcript will be sent to you providing an opportunity for you to amend or remove any information. The anonymised transcript may be viewed by my research supervisor and excerpts of the interview may be quoted directly in the final write-up of the research.

The recording of the interview will be destroyed on completion of the study and the transcript and other documentation will be stored for a period of five years in accordance with University of Chester guidelines.

**What will happen to the results of the research study?**

The completed study will be marked as part of my Master's degree and hopefully find appropriate publication in relevant journals. All participants would remain anonymous.

**Who is organising and funding the research?**

Supervised by the University of Chester, I shall be responsible for the organisation and funding of this research. Any phone calls necessary will be made by me thus covering the cost of the calls.

**Who may I contact for further information?**

If you would like more information about the research before you decide whether or not you would be willing to take part, please contact:

Nicola Terry, [email@nicolaterry.co.uk](mailto:email@nicolaterry.co.uk)

**Again, sincere thanks for your time and interest in this research.**

A list of qualified therapists can be obtained through the following websites:

*British Association of Counselling and Psychotherapy –*  
<http://www.itsgoodtotalk.org.uk/therapists/>

*UK Council for Psychotherapy –*  
<http://members.psychotherapy.org.uk/find-a-therapist/>

*British Association for Behavioural & Cognitive Psychotherapies –*  
<http://www.babcp.com/Default.aspx>

*Counselling Directory –*  
<http://www.counselling-directory.org.uk/>

**Appendix E: Participant pre-interview questionnaire**

Thank you for your interest in this research.

Over the course of this study, I hope to interview a range of different practitioners from varying contexts. Listed below are questions that will help me to gain a clearer idea about your potential suitability for this study. All answers will be treated with strict confidentiality and stored securely. Only details of participants selected for the study will be retained – all other forms of those not selected for interview will be destroyed.

If you are unsure about how to answer any of the questions, please do not hesitate to contact me (details at end of questionnaire).

**Name:**

**Gender:**

- 1. Are you a fully qualified counsellor/psychotherapist? Please indicate qualification.**
- 2. What is your theoretical orientation? E.g. person-centred, psychodynamic, CBT, etc.**
- 3. Are you currently in practice?**
- 4. Are you in regular supervision?**
- 5. In what types of setting(s) are you currently working with clients?**
- 6. Please describe the types of client work/issues that you commonly encounter or that you feel may be of interest during the interview:**

*Again, many thanks for your time and interest in this study. I will contact you on receipt of your completed questionnaire.*

**Nicola Terry:**

**; email@nicolaterry.co.uk**

**Appendix F: Participant consent form**



University of  
Chester

**Title of Project:**

How do counsellors and psychotherapists consider diet and nutrition with their clients?

**Name of Researcher:**

Nicola Terry

***Please initial box***

1. I confirm that I have read and understood the participant information sheet for the above study and believe I have been given sufficient information about the nature of this research, including any possible risks and have had the opportunity to ask questions. ☐
2. I give consent for the details of a written transcript based on an audio recorded interview with me and the above researcher to be used in preparation and as part of a research dissertation for the MA in Counselling Studies at University of Chester. ☐
3. I understand that my identity will remain anonymous and that all personally identifiable information will remain confidential and separate from the research data. ☐
4. I understand the transcript may be seen by supervisory tutors and the external examiner for the purpose of assessment and moderation. They are all bound by the British Association for Counselling and Psychotherapy Ethical Framework for Good Practice in Counselling and Psychotherapy. ☐
5. I am aware that I may stop the interview at any point or completely withdraw the interview before analysis and write up of the research. I understand I will have access to the transcribed material and be able to delete or amend any part of it. Transcripts will need to be kept for a period of five years and will then be destroyed. Upon completion of the study the recording will be offered to me, or, by prior agreement with me, destroyed. ☐
6. I understand that excerpts from the transcript will be included in the dissertation and will exclude any personally identifiable material. Copies of the dissertation will be held at the University of Chester and may be made available electronically through the University's digital archive system. ☐
7. I agree that without my further consent that some of the material may be used for publication and/or presentations at conferences and seminars. Every effort will be made to ensure complete anonymity. ☐
8. I agree to take part in the above study. ☐

\_\_\_\_\_  
Name of Participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Name of Researcher

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

*(1 for participant, 1 for researcher)*

## **Appendix G: Interview guide**

- Personal introduction followed by thanks to participant for time and involvement
- Check on safety of their environment, e.g. quiet, undisturbed, etc.
- Re-iterate confidentiality of interview;
- Refer to permission gained on consent form to record interview;
- Clarify that participant has seen categories of questions for interview (emailed prior to interview).

*Ok, first of all, I'd like to begin by asking you a few questions to get a clearer picture of your working life:*

### **a) Extent of therapeutic experience/route into profession (briefly)**

- Can you tell me how long you've been practising as a therapist?
- How did you come into the profession?

### **b) Work place settings (briefly)**

*You said on the pre-interview questionnaire that you work in a university setting as well as occasional private practice.*

- Can you tell me a bit about your current place(s) of work?
- And your clients?
- Have you worked in any other settings?
- Are you aware of any influence that any of these work settings may have had upon your therapy practice?

### **c) Theoretical orientation/role as therapist (briefly)**

*You said on your pre-interview questionnaire that you work as an integrative psychotherapist, using EMDR and hypno-psychotherapy when appropriate.*

- Is there anything else you'd like to add to that description of your therapeutic approach to client work?
- In your role as therapist, what would you say was your overall purpose or aim with your clients?

**\* CHECK TIME REMAINING – NEED AT LEAST 45 MINS**

*Ok, so as you know, this study is interested in how therapists with an awareness of dietary issues consider such factors in their counselling/psychotherapeutic work:*

**d) Origins/evolution of interest in dietary issues**

- How did you become interested in the effects of diet/nutrition upon mental health?
- What aspects of diet or nutrition are of interest to you?
- Do these relate to your own lifestyle in any way?
- Are you aware of any life events or aspects of your history that influence the way that you consider food/diet/nutrition?

*Now I'd like to ask you a bit more about how your knowledge plays a part in your client work:*

**e) Application to client work**

- What would be your usual way of approach with food/diet issues with clients?
- And how do you use the information given about food/diet?
- How do you decide when to utilise the information you have with clients?
- Are there times when you would choose not to engage with such information?

**f) Therapist experience/process**

- In light of the types of working you've mentioned, can you describe your experience when addressing such issues with clients?
- How do you feel after such times with clients?
- Do you ever discuss these issues in supervision?
- What types of responses have you had from your supervisor?
- What is this like for you?

<p>Conclude interview with thanks and availability to contact with any concerns following the interview process (refer them to information sheet for contact details). Inform participant that I will contact them in due course with a copy of the transcript of the interview for their feedback or any necessary adjustments.</p>
--

**Appendix H: Master tables of themes for all participants**

A. Personal aspects of the therapist		
	<i>Personal life history</i>	<i>line no.</i>
P1:	My mother was always good about having a massage and looking after her body	609-610
	I have a problem with my eyes, which had never been diagnosed	614-615
	Cos it's transformed my life, the omega 3 essential fatty acids	426
P2:	My mum cooked everything from scratch... we ate very healthily	428-429
	I grew up with a reasonable awareness of food	440
	Growing up in South Africa we had so much fresh fruit, so I love fruit	489-490
	Bit of a journey and a quest to try and find ways to manage my anaemia	449-450
	Explorations around food... trying to find a healthy balanced diet as a vegetarian... to look after my iron	468-470
	No one... got to the bottom of things and so it was a slow journey	486-487
P3:	My parents were in India and when I went home to my grandma she would 'feed me up'... on a lot of comfort food	840-844
	I am an emotional eater... I have, at one point in my life recognised I was bulimic and stopped doing it, basically	398-402
	I've got an autistic son... and found that there were certain allergies that he had that affected him... his behaviour	794-800
P4:	Food was a very important thing...finding out about wholefoods... processing of food...finding out about nutrition	294-299
	Working in a wholefoods shop... wholefoods warehouse... so it was a part of my life and part of my politics	310-315
	That was an important part of my life, my identity	332
P5:	I'm diabetic... I don't take medication. I've had serious cancer and come through it and I think it's if you're in the right frame of mind emotionally and bodily... with the food and nutrition	551-560
P6:	I can still link a lot of the memories of my mum and dad to food... many of my very positive memories of being cared for have a food element in them	529-538
	<i>Personal lifestyle</i>	
P1:	Went to two of everything, two homeopaths... medical herbalists, two acupuncturists	625-627
	I now max out on omega 3	642
	Udo's oil is bought as an oil that you can have a spoonful of or whip into smoothies	738-741
P2:	I've long been interested in it even in my own life	426-427
	It's very easy for me to eat fruit and like vegetables too... I do have a sweet tooth... that's not good news, but I think I manage it pretty reasonably, because I do so much on the healthy food side	492-497
P4:	I live with someone who grows food, grows organic vegetables... food is a big part of my life...still	1272-74
	If food is good, you can savour it can't you? Allow the simple pleasure... that's a very important part of it I think...if you really want to present a meal well on the plate, then you use, you've got all different colours... and smells... and aromas. You know, that it's a pleasant experience	1304-19
	I got my early diagnosis of my bowel cancer through an acupuncturist	1420-21
	I had breakfast before I talked to you and I knew that if I didn't eat my breakfast, it would affect our ability, my ability to enjoy this interview	1287-91
P5:	Food and nutrition, it's just a passion really	627-628
	Like I said before, it's part of me, it's what I do	1429-30



## A. Personal aspects of the therapist (cont.)

	<i>Therapist perceptions and beliefs regarding diet/nutrition</i>	<i>line no.</i>
P1:	I s'pose one of my things is, healthy body, healthy mind	612
P2:	We need life force, we need living energy	257-258
	What I learnt was... how much is within our realm to manage	799-801
	I find it so integral in life and to our job	1366-70
	It's part of self-care, you see, again with my philosophy... just because you're tired isn't an excuse to neglect yourself	877-879
	Peoples' perceptions are often, you know, I can't afford decent food... 'I'm living on such a tight budget' and for some it's true, but when you hear they're living on Pot Noodles... your heart sinks. That stuff should be banned	1250-58
	It'd be lovely if there was more nutrition covered across the board. When I see what people eat and even colleagues often drinking fizzy drinks when you know it's leaching phosphorus from the bones... you just think, 'whoah'	1372-79
P3:	I'm a great believer in 'we are what we eat'	522-523
P4:	For me, it's all one really cos I believe in the bodymind	569-570
	It feels an essential part of life... next to breathing	1266-68
	It is a very basic way we care for ourselves or we don't, isn't it?	1282-85
P5:	I see it as a part of life that if you eat right, then you feel right. You've got lots of energy, you can concentrate better... it just makes you more presentable, keeps you on an even keel	527-532
	You only have to look out there at the obesity rates... the way peoples' behaviour is and a lot of that is down to what they're eating, what they're doing... I think it forms the whole personality	1149-54
P6:	Favourite and least favourite foods and they're... nearly always linked to something psychological	392-397
	It's about looking after yourself, it's not just about the intake of food, it's making time for yourself, so food has a really... all sorts of implications	482-484
	Food is massively important to peoples' lives, much more important than a nutrient	314-316
	You have to realise that food might mean safety, hoarding food might mean safety	596-597
	Everybody needs food... everybody has some attitude towards food	705-709
	<i>Perceptions of the medical approach</i>	
P1:	The GP practice that I work at, the doctor that everybody wants to see, was also an endocrinologist, has Healthspan's telephone number written on her desk... So all the people that don't want prescriptions are given Healthspan's number and go and get St John's Wort... You know, people say, 'I'm depressed but I don't want tablets' It's only omega 3 essential fatty acids! How dare you not know this? When you were talking to me about being on steroids for the rest of my life? I feel incandescent with rage	810-817 1413-16
P3:	He said, 'do you know, if somebody'd said this to me, if I'd gone to the doctor and he'd even said something about water drinking or...' Cos I know it sounds silly but he just did not know	1235-38
P4:	The trouble is, really, again, that the National Health, very few people are trained in nutrition?	440-441
	Yes, well unfortunately, even in my case I got no nutritional advice after my surgery	452-453
	If food is that basic, why aren't... isn't the average GP got much nutritional expertise? Or why isn't there a nutritional expert at each GP surgery, see what I mean? Or even at least a specialist trained nurse	1524-31
	It's there's a gap in the NHS where there's not enough nutritional advice and it's very crude, you know. So for some people, the 5-a-day stuff will really click but there's loads of people, if you've grown up hating vegetables, it's not gonna work,	1382-91

A. Personal aspects of the therapist (cont.)

*Perceptions of the medical approach (cont.)*

P4: do you know what I mean, it's too... simplistic?

P5: She was always tired and on edge, so I started to talk about what, you know, what 355-357  
she'd tried herself cos she was getting nowhere with the doctor

Instead of, sort of, reaching for tranquilisers, which I've... I'm always surprised, the 597-602  
majority of people who come and are not medication don't really want to take it, it's  
not what they really want to do, so we talk about, you know, calming teas and things  
like that

B. Therapeutic approach and philosophy		
	<i>Learning and development</i>	<i>line no.</i>
P1:	Once you've started to look at risk factors [for an EAP], I think that's what encouraged me to take a step on to talk about other risk factors... like, what's your coffee intake	330-334
	I see a lot, that's why I ask about fizzy drinks, both the sweeteners and the caffeine and a lot of people have no idea how much they're drinking	1293-96
P2:	I started out with private practice... so I've always been conscious of wanting to give clients value, for their time and for their money. And in short-term service I'm used to working fairly concisely	210-217
	Working in the setting I am, it's a case of wanting clients to start to see results	228-229
	In the earlier stages I've, sort of, fine-tuned my wording a little	1429-30
	I've sort of discovered certain things are good... that I've learnt of things through trial and error	1696-99
P3:	[Working for the NHS] has made me possibly look at being a bit more efficient... you could say it's sharpened up that side of my practice	167-177
	So that [bulimic client] brought me into thinking 'goodness, how the nutritional side can affect people' because I noticed that when we got a sensible diet going... there was notice of mood change, confidence and her self-esteem grew	438-444
	I think as you get older and the more you practice... I have become more and more direct and immediate and I think that goes with confidence because you're meeting the same thing sometimes anyway	1597-1606
P4:	The settings have made me much more focussed and brief	159-160
P5:	[As a teacher with special needs students] we worked on energy foods, things that would keep out energy levels sustained and foods that were really a temporary fix... so it was through that... I thought 'this is working for the teaching side of it'	293-302
P6:	I do a lot of sharing now, I think when you're younger you're very anxious about boundaries and things	1337-39
	<i>Attitudes to therapy</i>	
P1:	It was discovered that he had a brain tumour and so from that, the way that was formulated in my mind for the future is, 'don't therapise a tumour'... So partly for my assessments with people is, let's clear the decks of any possibility of there being a physical cause for what's going on for you here	344-354
	What I feel I do is lay a smorgasbord in front of [the client], of thoughts and concepts and ideas... so that we're creating for [the client], it's not one size fits all	1648-56
P2:	I like quite hands-on ways of working	81-82
	I do like a holistic approach and nutrition certainly sits very much in that camp	85-86
	[Therapy] isn't just self-exploration. I believe that has a place but I tend to be more pragmatic than kind of just keeping it in say, a person-centred area session after session... for the most part I tend to be more directive	392-401
	I'm going to tailor it to the client and what I hear	834-836
	Knowing that, you know, one size doesn't fit all, everyone's different	1697-98
P3:	It is in quite a practical way... you know, 'would you like to tell me?'... little steps. That's the practical side	378-382
	I'm a creative worker, which means I use anything to suit the client	252-253
	I just think, 'what do they need?'	309
	I don't go 'I am a 'this type' of practitioner'... I've worked in a lot of different areas	751-760
	Actually, diet and nutrition are very strong in anxiety, to be honest, so... we're gonna do a little bit about that like we would do exercise	1466-70
	Definitely would work with all, what I call these other influences coming in	1187-88
P4:	I am a pragmatist... I'll go for what's best for my client, or offer things, you know	164-168

## B. Therapeutic approach and philosophy (cont.)

<i>Attitudes to therapy (cont.)</i>		<i>line no.</i>
P4:	offer a pragmatic set of things From the theory that I know, if I think it's helpful, that's the kind of person I am, I'll just offer anything and then the person can say	178-181
P5:	I do a lot of reading and I'm always looking at things from a different perspective and angle... because it's not, sort of, set in stone, is it? No, and I like the freedom to be able to move around and look at different theories and therapies... I might go in one day and just use Egan... because that's what's suitable for that client With the food and nutrition, it's all part of the whole thing really... you can't divide one from the other... [Holistic's] the word I use when I think about counselling Talking, going over the problem... letting them get it out... and then we have to work on a plan, a plan of action	149-160 560-565 661-665
P6:	I'm an evolutionary biologist and I use a lot of evolutionary biology in my psychotherapy and men are much happier with that... A lot of men are unhappy to go in through a psychological route and talking about how they feel or what they think, whereas if I'm talking about evolutionary biology techniques and describing a troupe of chimpanzees then they can often understand that quicker and feel much more comfortable with the explanations, although the end result is the same. I learned more about people doing evolutionary biology than I ever did doing psychology, I have to say I also look at the practical stuff... when people are depressed, they're often not eating as well as they should be, or over-eating and I just say to people, 'take a good vitamin and mineral and drink plenty of fluid, it doesn't matter about your food at the moment'... I'll try and get them to eat more sensibly, but also in a way they enjoy, and it gives people something to concentrate on... it's often quite useful when you feel lost in a sea of depression or anxiety I will just explore things, 'oh, that's a dead end, let's try this one'	83-100 418-431 1390-92
<i>Therapists' aims in therapy</i>		
P1:	The client is bringing a jigsaw puzzle and what I'm sort of doing with them... is going round the pieces of the jigsaw and going, 'well, this one doesn't quite fit there, let's have a look at it'	1258-64
P2:	I've also been interested in getting to the root cause of things It really is to help them to help themselves Get them to a place where they can self-sustain, you know, well-being Have more clarity and enhance their capabilities... fix it in a way that's going to carry them further I probably would be a natural educator, you know, in some capacity... I like to impart knowledge and be helpful I just feel I'm giving them choices and I'm raising awareness and that feels necessary to me If they have had help before from a therapist... you know, that area wasn't touched on, it feels nice to give them something new that's another piece of the puzzle	78-79 358 381-382 387-390 1409-13 1431-32 1553-56
P3:	I'm actually looking for clues... what it is that's affecting them most	368-369
P5:	It's about empowering the client It's all about knowing where your problems might arise, you know, is it a stress factor, is it a dietary factor, is it a lifestyle factor? And working through that If someone has to depend on alcohol and abuse it, there's obviously a reason for it there so it's getting right down to the core, peeling the onion When you get to the core of it, their childhood and past, what leads people to eat that and not have any control	371-372 455-459 640-646 1282-86

## B. Therapeutic approach and philosophy (cont.)

### *Therapists' aims in therapy (cont.)*

- P5: So, it's, you know, passing on knowledge and information 1382-83
- P6: To make them feel better about themselves and to help them realise that they have more control over their lives than they think they have 238-240
- Bits of information together and store them in my head until I've got enough to make a pattern... you know, 'we're all like jigsaws and you keep giving me pieces of your jigsaw but I haven't got the full picture yet, have you got a few more pieces to give me?' 1326-35

### *Maintaining the therapeutic alliance*

- P1: I mentioned this theory and he said, 'that's absolute rubbish' and I said, 'that's fine' and then changed the subject... he lacked confidence and I was trying to show him that whatever he thought was good, was good 1642-72
- P2: I might say, 'well, I understand that desire for natural health, that tends to be my leaning too 1051-52
- If they seem irritated or whatever, I'm not going to persist, I will drop it instantly. With other ones... I just don't wanna alienate them at the first session 1317-22
- I think the way I approach it often... is attuning to the client in terms of the level of detail I go into and you know, the wording I might select 1417-20
- Although I'll have some psycho-ed stuff in there I don't want it to come across as a sermon 1451-53
- P3: There was a big story to go through before we started tackling specific changes in diet and nutrition, I needed to hear the story first 509-512
- They decide which bit they want to change first and which is affecting them most 1098-99
- P4: That over-arching thing I said of trying to be there and see it from their point of view... empathy is important 665-669
- Something about their body language when we talk about food 1089-90
- It's just best to be alongside and if they're ready to work with it then they'll be ready to work with it 1163-65
- P5: If the client doesn't want to do it, then that's all well and good, you have to respect that 404-406
- P6: There's massive evidence of the therapist is much more important than the therapy 193-194
- 'What about eating, do you eat well?', so I'll bring it in... and then depending how they pick up on it, you know, I'll decide what I'm going to do 833-836
- You might think it is an issue from some of the things they've said, but if they don't see it as an issue there's certainly no use forcing it on them, you have to look for avenues 1150-57
- If they just shut up about it, you just keep it in your head 1276-77

### *Client responsibility and collaboration*

- P1: It's like, it's not what I'm gonna do for you, it's what am I going to help you to do for yourself... I mean, it's a very useful indicator, you know, if I'm talking to somebody about their coffee intake and their water intake and their junk food and then the next week they come and it's identical, it's like, ok, that tell us... that tells us a lot, doesn't it? 763-772
- 'Ok, let's talk about GI foods, go and research it, I'm not gonna tell you...' 793-794
- I say to people, 'go and look this up online, please don't take my word for it, please go and research for yourself, because I don't want to spoonfeed' 841-845
- With their permission and their guidance and me guiding them and them guiding me 1259-60
- P2: My ethos is very much to help someone to help themselves 230-231

## B. Therapeutic approach and philosophy (cont.)

### *Client responsibility and collaboration (cont.)*

P2:	It is very much, we're a team, I can help you with this but, you know, what's your part?' So I don't shy away from the collaborative nature of what needs to go on	235-240
	I just believe the change has to come from within... that it has to be some lifestyle changes and people need to expect that over the longer term they're gonna do things differently, again the quick fix just doesn't resonate	1491-96
P3:	I say, 'just let's try' or 'you try eating in a balanced way' and they can choose... I don't set out a diet for them	595-599
	It's like I always say to them that, 'I can help you but you're going to be your own detective in this'	1200-01
P4:	The young person, or whoever's coming forward, is acting like an adult, they are taking charge in coming forward for support, so it's a time to catch them, to have those conversations	792-795
	I don't recommend a person but I say, 'if you look in the Yellow Pages you'll see some and some of them will have qualifications after their name	829-831
P5:	I'm not a passive counsellor, I do expect homework	688-689
	I won't even sort of say, 'I see you didn't [make lifestyle changes], do you want to tell me why?' because I think, 'well, it's obvious isn't it?... they don't want to help themselves... they prefer things the way they are	1123-29

C. Diet and nutrition within the therapy process		
	<i>Assessing clients' presenting issues</i>	<i>line no.</i>
P1:	I see a lot of people with anxiety and depression, and this again is where we come back to the nutrition, routinely now as part of my assessment form... I now ask everybody about their coffee intake, their tea intake, their sweeteners intake and fizzy drinks... I mean one lady was having 20 coffees, 'ooh, do you think that might be linked with my anxiety?' Well, let's see shall we?	543-552
P2:	When you did the nutritional analyses, you had these wonderful charts and you could see at a glance... iodine level was really low and their calcium and magnesium was low and it's like, 'right! We've got lots of anxiety and exhaustion here... now what nutrients can they take, what food...'	689-697
	I was just horrified by the quantity of sugar that they were consuming in the course of the day and the sugary drinks... and then they were a bundle of nerves	810-815
	I do ask about their nutritional intake and how healthy it is and I'll come back to that, especially if they're presenting with aspects of mood disorder	821-826
P3:	Little children not being fed properly... crisps and fizzy drinks and we know now don't we? And trying to get across to [parents] that, 'well, no wonder they're high and excited'	770-778
	If there's an emotion that you can't really link to something else they're telling me in their story, it's just listening out for behaviours... maybe linked with diet and nutrition	987-991
	Getting snappy, angry, cross... they recognise they get like that when they've missed a cup of coffee or two. Or their sugar bar or you know, whatever it is that has been actually keeping them, in their words, 'calm'	1106-15
P4:	If we decide that [panicky clients] are thinking these thoughts at night and they're also having lots of caffeine... we might be talking about, 'are you, you know, drinking Coca-Cola or having coffee and tea late at night?'	614-619
P5:	Someone will come to you with a problem that's obviously very important, but if they're coming to you with a problem and they're emotionally all over the place and they're not eating right or sleeping right, then it's added to the problem 10-fold	566-573
P6:	Sometimes it's as simple as being hungry that makes people unable to cope	476-477
	They'll do a lot of exercise and are on odd diets, often have issues. They mightn't be very serious ones but they're often things that they're using to mask some anxiety or something else that's going on	1253-58
	<i>Exploring diet as part of lifestyle and self-care</i>	
P2:	It just helps me have an understanding of them... I start asking what physical exercise they do and you know, what's their normal nutritional intake... what veggies, fruit, what would they normally eat, how balanced, do they tend to eat a lot of fast food	919-925
P3:	What's their day like? Have they got time to sit? Have they got time to eat? I wonder what they're eating?	720-725
	I look at how they're affected in their lives on a physical and emotional and behavioural way... if I think there's something flagged up that might be around diet and nutrition, really I'm listening out for... 'oh, that's interesting'	915-930
P4:	The health questions proved really useful, so there are 3 questions about appetite, diet and weight... they're coming mostly with emotional or mental health problems and then you would be asking, 'what's your health like?'	417-426
	So we just talk about some ways of being calm and giving oneself stuff that is actually self-caring rather than... a huge bar of chocolate as a reward for an essay	1213-18
P5:	Someone's in front of you saying, 'oh, I never sleep'... you have to work on what exactly is happening, 'what are you eating before you go to bed? What are you eating in the day to keep your blood sugar levels?' You know, 'how much exercise	1313-21

## C. Diet and nutrition within the therapy process (cont.)

### *Exploring diet as part of lifestyle and self-care (cont.)*

- P5: do you get?'  
P6: I'll often go through their lifestyle about different things they can do... 'oh, do you like exercise?' or 'do you like reading?' or 'what about eating, do you eat well?' 829-834

### *Use of dietary intervention*

- P1: I mean omega 3, I've got some Udo's oil leaflets that I used to hand out 802-803  
Explain what sweeteners do in the body... you get a blood sugar spike, insulin kicking in to bring it back down and then I would draw a diagram of, you know, these spikes going up and down and then always they go, 'ohhh, is that why I feel...?' 1306-16
- P2: I will explain to them briefly, you know, 'do you realise that such a high percentage of your brain cells are actually coated with fat and the cells, if they can't get the right kind of fat, the cells get misshapen and the electrical impulses can't travel as efficiently' 295-299  
'Let's look at what you're doing to try and help yourself, you know, tryptophan is something that helps your serotonin levels...bananas, do you... would you have some yoghurt... brown rice?' 1053-59  
'If you eat something like avocado, avocado and wholegrain bread is wonderful for its magnesium levels, is that something you might have? Or sardines on toast is good with omega 3' 1094-99
- P3: I might talk to them about, you know, what's healthy, what makes you feel better... especially the sugar... you're not eating and you pick up a bag of sweets or a bar of chocolate... not long, let's say half-hour to an hour, feel really sink-y? 601-613  
You need to find out what you *are* eating and *when* you are eating because if you want to control [comfort eating]... you need to come in and put in some strategies to control it, so the food diary's quite good 1068-73
- P4: We explore then 'how many meals a day are you eating?... use crude analogies like, 'you wouldn't expect your car to go from A to B with no fuel in its tank so why do you expect to get through the day and study, you know, and use your brain without any fuel for your body?' 514-524  
We often talk about the reparative effect... the lovely effect of going out with friends for a meal... the social aspect... for some students who are lonely or they're over-working, you know, like one's anxiety about one's course... it's really important to just go out for a meal. So I might explore with a student, 'what would cheer you up now?' 949-960
- P5: Look at a diet sheet as part of the counselling, about issues around, you know, her moods... and when she'd come back we'd evaluate 323-339  
I'd look at the diet and we'd change things... like if there was too much refined foods, looking at foods that, you know, boost serotonin, tryptophan... I'd most probably say, 'have you looked at your diet and do you know that certain foods can have a chemical reaction, as can medication? And would you be interested in, sort of, helping yourself rather than depending on medication and have a word with your GP' 1077-99
- P6: Things like dried fruit is very good for people... who feel they're not eating enough, but they haven't got time, so I'll 'carry dried fruit' 897-899  
Maybe try and weave in slightly better ways of doing what they're doing... don't throw out what they're doing... modify it a little bit or get them to see there are better ways of doing what they're doing and maybe feeling a bit better about themselves 963-973



### C. Diet and nutrition within the therapy process (cont.)

#### *Client responses to interventions*

- |     |   |           |
|-----|---|-----------|
| P1: | I said to him about omega 3 essential fatty acids and at the end of the week he rang me... and he said, 'well, I've been for a run twice... I've got endorphins flooding round my body... and I'm taking omega 3 essential fatty acids and I don't know what anxiety is, I've got nothing to talk to you about'         | 386-399   |
|     | She was bulimic, so she cut out the sweeteners and then 2 or 3 weeks later she said, 'I thought I'd just have a trial to see whether, you know... what the sweeteners were doing' and had a day of some sweeteners again and the bulimia was right back in place  | 573-579   |
| P2: | I get the impression some of them do give it more thought, and certainly some will tell me they're now preparing lunches and bringing little lunches with them to campus... they've now got a bag and put almonds in their bag if they're snackish rather than always having that chocolate bar                         | 857-865   |
|     | Sardines on toast is good with omega 3 and they do start nodding, saying, 'ooh, well, you know, it's like, that doesn't sound too complicated'  | 1099-1101 |
|     | Once in a while I do get one of the ones who just won't eat a vegetable... is non-negotiable and, you know, that's just the way it is   | 1286-89   |
| P3: | If [my bulimic client] ate a balanced diet, she then wasn't craving... if she kept to a diet like that then she wouldn't binge and wouldn't want to make herself sick, and you see [bingeing] made her feel bad about herself so there was a link with the self-confidence and self-esteem                              | 458-472   |
|     | Occasionally there are people that, you're stood on your head, done everything and there's no way they're going to change... even if you take a tiny aspect, they still don't change  | 1673-82   |
| P4: | I said, 'well, it sounds like you've got some allergic reactions to the food... why don't you go to a nutritionist... and she sent me a card later saying, 'I've found out I'm allergic to this, this and this and I'm much better if I've avoided those foods'   | 487-496   |
|     | They seem to be conscious about caffeine although some of them totally ignore it and ignore the need for sleep... It goes through a whole spectrum, from people who are being very careful and drinking herb tea... or water in the evening, to people who are completely ignoring any advice and say it doesn't matter | 625-639   |
|     | Some of them say, you know, the odd person says, 'I hate vegetables'  | 1241-42   |
| P5: | People just don't associate the two, they think it's all about, you know, the mind and you can sense the tension and the anger and the frustration with a few of them who come in and think it's all about the emotional side and nothing else  | 844-848   |
|     | Well, it was a bit like, 'well, I'll just stick to the medication, it's easy'   | 863-864   |
| P6: | I said, 'let's just listen to what you've just said there: I used to eat quite well' and he said, 'yeah, you're right, I used to have a breakfast in the morning'... he decided it was a problem... he recognised it  | 884-892   |
|     | I work with a lot of personality disordered people... you'll slave away and you know, you'll just get it thrown back in your face, 'oh, that didn't help'   | 1466-75   |

D. Considering ethical practice		
	<i>Working with competence</i>	<i>line no.</i>
P1:	But [I always discuss food] in the context of 'this is now counselling, please go and research that yourself, please go and consult with your doctor, consult with a nutritionist, you know, I'm not saying I'm an expert	902-907
	'Institute of Optimum Nutrition recommends 2 spoonfuls of seeds', this, that and the other, but yes, it's not setting myself up as what I'm not	919-922
	I'm very keen on BACP guidelines on maleficence... I'm not allowed to cause people any harm... sometimes I've said to people, you know, 'my code of ethics says that I'm not allowed to harm you so we're not gonna go there' or 'we're not gonna do that'... I would laugh about it but I do take that very, very seriously indeed	1522-41
P2:	Whilst I wouldn't, you know, tell people what they should or shouldn't do, I'd certainly make suggestions... or suggest they discuss things with their doctor	544-547
	There's various things, you know, that once in a while if somebody mentions something you know, I just jot something down and say 'well, look into this... I'm not a doctor, I'm not prescribing, but... this is quite a good product that might be of interest	1719-25
P3:	I'm very careful, I don't pronounce on any foods to people, I just talk to them... 'I wonder what's going on...'	810-815
	Remember, they don't come in specifically for the diet or nutrition, that's just the way I work	912-915
	Cos you can get it wrong... if you go straight in with food and diet, you know, it can be a bit of a minefield actually	1084-88
P4:	I wouldn't claim to be an expert... I was just saying, 'consult an expert who's got time and they'll be interested'	497-499
	I wish there was more. Not that I would do because I don't feel that [diet] would be my area of expertise, but I wish that there was more that they could refer to, to get help	1355-60
P5:	It's about that as well, being careful what you say and what advice you give...if someone came and I said, 'oh, why don't you take some B vitamins for your nerves?' I would never dream of doing that. I don't know what their medication is	387-395
	Anyone that takes St. John's Wort, it can have an effect with medication and so on, so always check it out with your GP, or your practice nurse	476-479
	So you've always got to... I'm constantly doing research around, you know, food and nutrition	626-627
P6:	[Diet] has to be an issue that, either they've brought up or they've given you an avenue where it would be useful to bring it up... again, it's how well you know people	1139-44
	It is hard to get to know people and I could be completely down the wrong track	1310-11
<i>Socio-economic issues in diet and nutrition</i>		
P2:	There will be some students... where we might rarely go into the nutrition side... they usually come from more affluent homes... they struggle a bit, but they had a very solid base that they've grown up from...so I often find they tend to be quite good in their food choices	1178-91
	I would say that when I was working up north... [the lack of healthy eating habits] did seem to be the level of, kind of, I don't know, deprivation that they grew up in	1240-44
	Peoples' perceptions are often, you know, 'I can't afford decent food'... 'I'm living on such a tight budget'	1250-53
	I would definitely say that there's a level of, sort of, education and some of the social class side does feed into that... some of those students, who've come from more privileged backgrounds... it's almost such a no-brainer, the habits were entrenched at such an early age	1260-71

#### D. Considering ethical practice (cont.)

##### *Socio-economic issues in diet and nutrition (cont.)*

- P4: The trouble is... that the National Health, very few people are trained in nutrition. So I would be saying, 'if you've got some money at some point... or if you've got some money now, you could go and see a nutritionist' 1420-27
- Obviously I feel wary of asking students to spend money on going to see a kinesiologist [for allergies] 440-448
- P5: Well, it was a bit like... 'I can't afford to buy, you know, green tea' or whatever. So that's fair enough 1408-09
- P6: Blueberries, yes they are good for you but they cost 4 times as much as something else that's just as good for you 863-865

##### *Awareness of own process as therapist*

- P2: Seeing your questions was certainly a pause for reflection on something I probably haven't thought about for a while because I've just, kind of, got into a flow of 'this is how I do it' 1079-81
- P3: I'm very strong on transference and counter transference, I must say 1510-12  
But I'm aware myself when I'm working with someone... often it triggers things in me... My own experience of emotional eating, definitely 1540-52  
[When a client resists] you have to take that back and think, 'did I push? Was I banging on too much about nutrition or something?'... and analyse it and reflect on it and wonder 1687-90
- P4: You just feel, you know, part of what I'm working with is my personal interests, aren't I? My personal values 1502-05

##### *Experience of supervision*

- P1: My sense is that she doesn't do it to the extent that I do, but... on board with the idea that that would be, you know, a good thing 1513-16
- P2: Mostly she stays very much in her model, so no, in fact it's very rare that I get a chance to bring it up in supervision 1610-12  
I had a supervisor who was also very interested in the holistic approach to things... it was supervision, but there would also be a little sort of, personal element type thing as well... we had the nutrition banter 1662-81
- P3: She's also very good... if I describe some of the body work... and what happens within the body that often does link into diet and nutrition, so you know, she's another point of call 1526-32  
I've got a colleague... we do some peer supervision from time to time... we share our own ideas... this is more of a holistic way but obviously diet and nutrition comes into it 1654-60
- P4: I don't get that much response, if I'm honest... I don't feel like it's dimension that's really opened up 1495-98
- P5: Usually when we're discussing it in a [supervision group] session, other counsellors are saying, 'ooh, that's a good idea, I might try that myself!' 1378-80  
Well, when I'm talking about it they're usually, 'that's a good idea' 1397-98
- P6: I really like her and we do a lot of peer supervision, so food is a very important issue 1527-29

### **Appendix I: Excerpts from researcher's self-interview**

My current places of work? – I run my own small private practice... I also work 2 days for an HIV charity organisation... a huge variety of problems, with HIV being the only common denominator... although I work with a lot of gay men and in more recent times our black African membership has increased as well who often bring many asylum related issues... my private clients tend to be middle class or professionals.

Have I worked in any other settings? Yes, I worked for a mental health centre, [and clients] were from the more marginalised oppressed social groups... and they had a lot of different kinds of problems. They were long-term users of the mental health service so they'd often had many encounters with psychiatrists and medication.

Any influence any of those work setting may have had upon my therapy practice? Erm, I think the HIV charity has provided the biggest influence on me, mainly because I suppose I've been there for the longest time and done the most work there... I think it's verging on the impossible to work with the kind of oppression that I work with and witness the feelings... due to inequality, injustice, war... homophobia and negative attitudes to HIV and the stigmatisation of an illness and the blaming and all that kind of stuff and not be politicised... you know, you can't just sit by and be passive about that.

All of that has fed into the way that I practice therapy now and I don't shy away from addressing the social attitudes that we're surrounded by, in therapy. I think politics is in the room always, represented by ethnicity, clothes, cars, the room, the décor... accents... vocabulary, education, the fee you charge... all that stuff is political to me.

The mental health centre... I mean that was the first place I worked and coming from the working class background that I come from... that client group, who were by and large from poor backgrounds [were] very very similar to a lot of the people I knew, or my own background... touched on that sense of injustice and... the nature of mental health services when you can't, kind of, pay for things.

Theoretical orientation? I think, again, my theoretical orientation was influenced by my settings, so working with an illness like HIV... for me is not about sitting there and working with emotional and cognitive processes in a congruent, empathic fashion ... that's a huge part of it but I think you need to be able to ask the questions about self-care and you need to be able to provide information about how you might do that better. At the end of the day, if

someone's sat there with a life-threatening illness, spiralling into disrepair you need to feel confident to address that... and not preach at people but again, hold it as part of the therapy.

Also I work as part of a multi-disciplinary service so I think I've been influenced by that as well, that you know, just outside my room are body therapists and social workers and support workers and outreach workers and... you know, a whole bundle of stuff that reminds you of the holistic nature of caring for people, that therapy can't possibly address everything for someone, they need to have as many bits and pieces, you know, available as possibly really.

So, in my role as a therapist, what would I say my overall purpose or aim was with my clients? The first word that springs into my mind is empowerment and again, I think that comes back to the political position I find myself in as a therapist very often, erm... so, to enable awareness of one's relationship with oneself, of one's relationship with others and the way we behave in that... to develop inner and outer support networks as well... empowerment comes back to the centre of that, that if you don't feel sufficiently empowered, you're not able to then find help very well.

How did I become interested in the effects of diet and nutrition on mental health? My own ill health; about 4 years ago now, I was becoming more and more unwell. I was constantly, pretty much constantly fatigued, my body was *craving* sugar... I fed myself considerable amounts of sugar. I'd given up alcohol about 3 or 4 years prior to that and that made a massive difference, but I now know that it was the high level of sugar and yeast, erm, and the subsequent candida overgrowth, the yeast overgrowth... that pervaded my whole being and left me pretty toxic, so over the past 3 or 4 years my goal was to clean it up,... I did that pretty much on my own for the first few years, I'm now under the guidance and care of a nutritional therapist,... I watched my body change hugely and with that my mental health: anxiety and depression.

So what aspects of diet and nutrition are of interest to me? ...I suppose in terms of clients, anxiety and depression, as the areas of mental health that I think can be affected and... you know, in part, remedied often with diet, I mean if we look at anxiety for example – low blood sugar, dehydration, too much sugar, so spikes in blood sugar, eating high sugar foods, skipping breakfast... and omega 3, as well,... there's also something for me about making that commitment for yourself, changing your life pattern so that you have the time to buy food and prepare it and sit and eat it. On your own that is not an easy thing to do, I encounter a lot of people who struggle with that... 'if it's just for them, what's the point?' ... I suppose there's a bit of me... old family values as well, you know, sitting together and sharing food at a table.

I mean, when I was younger [I was] just totally not interested in that but I really see the value and the part that plays to a couple or a family, to catch up... and *sit still*, to stop! When do you stop long enough to... be aware of how you're feeling, of how your body's feeling, of what your mind's doing, how full you are mentally; when do you get the chance to digest... in all senses of that word?

What would be my usual approach with food/diet issues with clients? It's gradually developing... I don't work heavily with it, I suppose I hold it in awareness... if it gets flagged, I'll go with it. So I don't start out with an eye on that particular ball... I suppose, that's quite person-centred in a lot of ways. I'll start with what the client wants from me... I suppose my ears would be pricked if someone was talking about anxiety and I would then be... caffeine... it's amazing how many [clients] I've worked with who don't realise what caffeine is in. So they know coffee, that's an obvious one... not very many know about tea, or green tea... chocolate gets overlooked and Coca Cola, diet coke... people will be drinking tea and coffee right up until bed time. I have to be, kind of, mindful of my passion about, eliminating these things that I feel are far from helpful in terms of these mental health issues and just offer basic explanation, information about how that caffeine will be affecting them... I'd be interested to ask 'what are you eating on an average day?' You know, 'do you have breakfast, what would you have?' 'How long would you wait before you ate again?' 'And what would you eat then?' You know, 'do you skip any meals, do you have an evening meal, do you cook it?' You know, 'or is it out of a packet?' just so I could get an idea... whether their low blood sugar could be playing a part, you know, cos I am aware that some of the symptoms of anxiety or depression, certainly like lethargy or jumpiness or twitchiness or whatever, can absolutely be down to a lack of drinking of water or, you know, the fact that your body's got no fuel to run on. You know, I do say that to clients, you know, 'you wouldn't expect to, you know, (laughs) pee in the tank of your car and expect it to drive properly', you just wouldn't and if you're doing the equivalent to your body it ain't gonna work for you, you know, your brain as an organ needs stuff, good stuff, to make it work. It needs water, absolutely, but it needs good fats and you need glucose in your blood stream to make everything run. I'll... explore what food might mean to people as well, you know, obviously that's really important and, and can have roots in someone's childhood and the way they were shown to treat food, how it's been picked up from family members... and an indicator of how the client, again, feels about themselves, how they're treating themselves, how much they're committed to taking care of themselves in terms of eating.

How do I use the information given about food or diet? For example, I had a client... he doesn't necessarily know where's he's going to be living in a month's time, I was aware at

the same time that his ability to cope with the pressures of all of this stuff was seriously lowered because he had no food in his body. He wasn't drinking [water], then he was describing how he would chain smoke because that felt good and drink tea because that kept him going and then would, kind of, go on manic walks, you know, and then get a bit of a low but then would top up on tea and as I was describing what that might be doing it was like a light went on, he was like 'oh my God, that does absolutely fit with, you know, how I feel'. So although he wasn't necessarily able to go away and follow all the... advice... he at least understood about some of the factors in his day that were contributing to his anxiety, and he did come back and say that he'd, kind of, stopped doing what he'd done because he now knew that it wasn't helping him. He was still struggling to get food in his body because he felt sick a lot of the time because he was nervous and anxious, but he was drinking more water... just the way he was thinking about eating and taking care of himself just shifted... I suppose that there was a degree of control that he did have in a life that was out of control, there were tiny things that were in *his* control that he *could* do... it wasn't about the direct impact of food plus water equals better health, it was the psychological impact of that as well... to get a tiny bit of power back, you know, in your life, I think... really crucial.

How do I decide when to utilise the information I have with clients? I'd read body language, whether there was defensive posture, tone of the voice, eye contact... whether they'd glazed over or not, sometimes I'll joke and say... 'I hold my hands up'... communicate that I am bothered about food, so that it sits with me as opposed to being this universal truth that they must follow if they're gonna be good people...

In light of the types of working I've spoken about, can I describe my experience when addressing such issues with clients? It's a part of our life as animals... it's just one of those things that is shaping you and enabling or disabling you in your daily life... so when I talk about these things... because I care about it, talking about it with clients, it's a variable experience. Sometimes it's joyful because you can see people make a real difference to themselves and feel better, and they come back and they say 'ohhh, I wasn't gonna bother buying any food this week but I've been to the shop twice and I've bought this stuff and I've started doing a stir fry every day' or, you know, 'I've been eating a banana every day this week' or even just, you know, little things like that that mean they're coping better, those times are great. Other times, very frustrating... very disheartening.

So, after such times with clients? Like I say, sometimes heartened, sometimes disheartened... I've also been frustrated, I mean I had a client recently that told me that their

psychiatrist had recommended drinking Coca Cola to alleviate dry mouth and to help with symptoms of depression... to say it horrified me doesn't even touch it.

Do I ever discuss these issues in supervision? Yeah, as well as my own health: when I was on my diet and my physical health was changing, I would take that to supervision as part of my check in as to my well-being, and actually my supervisor's asked me about my diet and the book that I worked from... she was very interested,... she's very, into adventure therapy and exercise so I know that, you know, she's aware of that physical aspect of mental health, and I think the two are quite inter-related really – if you're aware of what your body's doing, you know, your mind isn't... far away ... so I think she is pretty supportive... as supervision is supposed to be about... whatever it is you're working with, I think you need to be reminded that you're bringing yourself to that encounter and your baggage and your stuff, you know, so... it's very easy to think, 'well, this worked for me, it can cure the world' which obviously, is not true... so to be aware of that evangelical feeling, that you can often get when you've created good health for yourself to not then think that that's necessarily the way forward for everybody else.

So, what is it like for me to get those kind of responses from my supervisor? Great. I feel it supports my growth as a therapist and as a person, to feel valued and heard... I don't think I would be able to work with a supervisor who dismissed my ideas about diet.